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UNIFORMED SERVICES HEALTH PROFESSIONS REVITALIZATION ACT OF 1971

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HEARING

BEFORE THE

SUBCOMMITTEE ON GENERAL LEGISLATION

OF THE

COMMITTEE ON ARMED SERVICES

UNITED STATES SENATE

NINETY-SECOND CONGRESS

SECOND SESSION

ON

H.R. 2

TO ESTABLISH A UNIFORMED SERVICES UNIVERSITY OF
THE HEALTH SCIENCES AND TO PROVIDE SCHOLARSHIPS
TO SELECTED PERSONS FOR EDUCATION IN MEDICINE,
DENTISTRY, AND OTHER HEALTH PROFESSIONS, AND FOR
OTHER PURPOSES

JANUARY 19, 1972

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H.R. 2—UNIFORMED SERVICES HEALTH PROFESSIONS REVITALIZATION ACT OF 1971

WEDNESDAY, JANUARY 19, 1972

U.S. SENATE,
SUBCOMMITTEE ON GENERAL LEGISLATION
OF THE COMMITTEE ON ARMED SERVICES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 212, Old Senate Office Building, Senator Harry F. Byrd, Jr., of Virginia (chairman) presiding.

Present: Senators Byrd, Jr., of Virginia (presiding), Bentsen, and Schweiker.

Also present: Charles J. Conneely, L. R. Garcia, and Edward B. Kenney, professional staff members.

Senator BYRD. The committee will come to order.

I am delighted to welcome today Dr. Richard S. Wilbur, Assistant Secretary of Defense for Health and Environment, to hear his testimony on H.R. 2 which is known as the Uniformed Services Health Professions Revitalization Act of 1971. For the record, bills S. 853 and S. 1317 are presently pending before the committee. These bills have the same objectives as H.R. 2, although they vary somewhat in language from H.R. 2.

It should be noted, however, that H.R. 2 will be the vehicle by which we consider the objectives of S. 853 and S. 1317.

(H.R. 2 follows:)

[H.R. 2, 92d Cong., first sess.]

AN ACT To establish a Uniformed Services University of the Health Sciences and to provide scholarships to selected persons for education in medicine, dentistry, and other health professions, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Uniformed Services Health Professions Revitalization Act of 1971".

SEC. 2. Title 10, United States Code, is amended as follows:

(1) By adding the following new chapters after chapter 103:

"Chapter 104.—UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

"Sec.

"2112. Establishment.

"2113. Board of regents.

"2114. Students: selection; status; obligation.

"2115. Graduates: limitation on number electing to perform civilian Federal duty.

"2116. Reports to Congress.

"2117. Appropriations: limitation.

"§ 2112. Establishment

"(a) There is hereby authorized to be established within 25 miles of the District of Columbia a Uniformed Services University of the Health Sciences

(hereinafter referred to as the "University"), at a site or sites to be selected by the Secretary of Defense, with authority to grant appropriate advanced degrees. It shall be so organized as to graduate not less than 100 medical students annually, with the first class graduating not later than 10 years after the date of the enactment of this chapter.

"(b) Except as provided in subsection (a), the number of persons to be graduated from the University shall be prescribed by the Secretary of Defense.

"(c) The development of the University may be by such phases as the Secretary of Defense may prescribe, subject to the requirements of subsection (a).

"§ 2113. Board of regents

"(a) The business of the University shall be conducted by a Board of Regents (hereinafter referred to as the "Board") with funds appropriated for and provided by the Department of Defense. The Board shall consist of—

"(1) nine persons outstanding in the fields of health and health education who shall be appointed from civilian life by the President, by and with the advice and consent of the Senate;

"(2) the Secretary of Defense, or his designee, who shall be an ex officio member;

"(3) the surgeons general of the uniformed services, who shall be ex officio members; and

"(4) the person covered by subsection (d).

"(b) The term of office of each member of the Board (other than ex officio members) shall be six years except that—

"(1) any member appointed to fill a vacancy occurring before the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term;

"(2) the terms of office of the members first taking office shall expire, as designated by the President at the time of the appointment, three at the end of two years, three at the end of four years, and three at the end of six years.

"(c) One of the members of the Board (other than an ex officio member) shall be designated by the President as Chairman. He shall be the presiding officer of the Board.

"(d) The Board shall appoint a Dean of the University (hereinafter referred to as the "Dean") who shall also serve as a nonvoting ex officio member of the Board.

"(e) Members of the Board (other than ex officio members) while attending conferences or meetings or while otherwise performing their duties as members shall be entitled to receive compensation at a rate to be fixed by the Secretary of Defense, but not exceeding \$100 per diem and shall also be entitled to receive an allowance for necessary travel expenses while so serving away from their place of residence.

"(f) The Board, after considering the recommendations of the Dean, shall obtain the services of such military and civilian professors, instructors, and administrative and other employees as may be necessary to operate the University. Civilian members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary of Defense so as to place the employees of the University on a comparable basis with the employees of fully accredited schools of the health professions within the vicinity of the District of Columbia. The Board may confer academic titles, as appropriate, upon military and civilian members of the faculty. The military members of the faculty shall include a professor of military, naval, or air science as the Board may determine.

"(g) The Board is authorized to negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in or near the District of Columbia. Under such agreements the facilities concerned will retain their identities and basic missions. The Board is also authorized to negotiate affiliation agreements with an accredited university or universities in or near the District of Columbia. Such agreements may include provisions for payments for educational services provided students participating in Department of Defense educational programs. The Board may also, subject to the approval of the Secretary of Defense, enter into an agreement under which the University would become part of a national university of health sciences should such an institution be established in the vicinity of the District of Columbia.

"(h) The Board may establish postdoctoral, postgraduate, and technical institutes.

"(i) The Board shall also establish programs in continuing medical education for military members of the health professions to the end that high standards of health care may be maintained within the military medical services.

"§ 2114. Students: selection; status; obligation

"(a) Students at the University shall be selected under procedures prescribed by the Secretary of Defense. In so prescribing, the Secretary shall consider the recommendations of the Board. However, selection procedures prescribed by the Secretary of Defense shall emphasize the basic requirement that students demonstrate sincere motivation and dedication to a career in the Uniformed Services.

"(b) Students shall be commissioned officers of a uniformed service as determined under regulations prescribed by the Secretary of Defense after consulting with the Secretary of Health, Education, and Welfare. Notwithstanding any other provision of law, they shall serve on active duty in pay grade O-1 with full pay and allowances of that grade, but shall not be counted against any prescribed military strengths. Upon graduation they shall be appointed in a regular component, if qualified, unless they are covered by section 2115 of this title. Students who graduate shall be required, except as provided in section 2115 of this title, to serve thereafter on active duty under such regulations as the Secretary of Defense or the Secretary of Health, Education, and Welfare, as appropriate, may prescribe for not less than seven years, unless sooner released. The service credit exclusions specified in section 2126 of this title shall apply to students covered by this section.

"(c) A period of time spent in military intern or residency training shall not be creditable in satisfying an active duty obligation imposed by this section.

"(d) A member of the program, who under regulations, prescribed by the Secretary of Defense, is dropped from the program for deficiency in conduct or studies, or for other reasons, may be required to perform active duty in an appropriate military capacity in accordance with the active duty obligation imposed by this section.

"§ 2115. Graduates: limitation on number electing to perform civilian Federal duty

"Not more than 20 per centum of the graduates of any one class at the University may agree in writing to perform civilian Federal duty for not less than seven years following the completion of their professional education in lieu of active duty in a uniformed service. Such persons shall be released from active duty upon the completion of their professional education. The location and type of their duty shall be determined by the Secretary of Defense after consultation with the heads of Federal agencies concerned.

"§ 2116. Reports to Congress

"The Secretary of Defense shall report to the Committees on Armed Services of the Senate and House of Representatives on the feasibility of establishing educational institutions similar or identical to the Uniformed Services University of the Health Sciences at any other locations he deems appropriate. The last such report shall be submitted by June 30, 1976.

"§ 2117. Appropriations: limitation

"Annual and supplemental appropriations for the Department of Defense are authorized for the planning, construction, development, improvement, operation, and maintenance of the University and to otherwise accomplish the purposes of this title. However, when utilized for construction of facilities, the portion of the authorization for appropriations so utilized will not exceed \$20,000,000 in any one fiscal year unless otherwise specifically authorized by the Congress.

"Chapter 105—ARMED FORCES HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

"Sec.

"2120. Definitions.

"2121. Establishment.

"2122. Eligibility for participation.

"2123. Members of the program : active duty obligation ; failure to complete training ; release from program.

"2124. Members of the program ; numbers appointed.

"2125. Members of the program ; exclusion from authorized strengths.

"2126. Members of the program ; service credit.

"2127. Contracts for scholarships ; payments.

"§ 2120. Definitions

"In this chapter—

"(1) 'program' means the Armed Forces Health Professions Scholarship program ;

"(2) 'member of the program' means a student officer who is enrolled in the Armed Forces Health Professions Scholarship program ; and

"(3) 'course of study' means education received at an accredited college, university, or institution in medicine, dentistry, or other health profession, leading, respectively, to a degree related to the health professions as determined under regulations prescribed by the Secretary of Defense.

"§ 2121. Establishment

"(a) For the purpose of obtaining adequate numbers of commissioned officers on active duty who are qualified in the various health professions, the Secretary of each military department, under regulations prescribed by the Secretary of Defense, may establish and maintain a health professions scholarship program for his department.

"(b) The program shall consist of no more than four years of courses of study, with obligatory periods of military training.

"(c) Persons participating in the program shall be commissioned officers. Members of the program shall serve on active duty in pay grade O-1 with full pay and allowances of that grade. They shall be detailed as students at accredited civilian institutions, located in the United States or Puerto Rico, for the purpose of acquiring knowledge or training in a designated health profession. In addition, members of the program shall, under regulations prescribed by the Secretary of Defense, receive military and professional training and instruction. However, members of the program authorized under the provisions of this chapter shall not be detailed as students to any institution of higher learning if that institution has adopted a policy which bars recruiting personnel of any of the Armed Forces from the premises of that institution or if such institution of higher learning has directed the disestablishment of Reserve Officers' Training Corps units at the institution despite the desire of the Armed Forces to continue such training at the institution.

"§ 2122. Eligibility for participation

"To be eligible for participation as a member of the program, a person must be a citizen of the United States and must—

"(1) be accepted for admission to, or enrolled in, an institution in a course of study, as that term is defined in section 2120(3) of this title ;

"(2) sign an agreement that unless sooner separated he will—

"(A) complete the educational phase of the program ;

"(B) accept an appropriate reappointment or designation within his military service, if tendered, based upon his health profession, following satisfactory completion of the program ;

"(C) participate in the intern program of his service if selected for such participation or, if not so selected, be released from active duty, under regulations prescribed by the Secretary of Defense, for a period of approximately one year to undergo intern training at a civilian hospital ;

"(D) participate in the residency program of his service, if selected ; and

"(E) because of his sincere motivation and dedication to a career in the uniformed services, participate in military training while he is in the program, under regulations prescribed by the Secretary of Defense ; and

"(3) meet the requirements for appointment as a commissioned officer.

"§ 2123. Members of the program: active duty obligation; failure to complete training; release from program

"(a) A member of the program incurs an active duty obligation. The amount of his obligation shall be determined under regulations prescribed by the Secretary of Defense, but those regulations may not provide for a period of obligation of less than one year for each year of participation in the program.

"(b) A period of time spent in military intern or residency training shall not be creditable in satisfying an active duty obligation imposed by this section.

"(c) A member of the program who, under regulations prescribed by the Secretary of Defense, is dropped from the program for deficiency in conduct or studies, or for other reasons, may be required to perform active duty in an appropriate military capacity in accordance with the active duty obligation imposed by this section.

"(d) The Secretary of a military department under regulations prescribed by the Secretary of Defense, may relieve a member of the program who is dropped from the program from any obligation imposed by this section, but such relief shall not relieve him from any military obligation imposed by any other law.

"(e) Any member of the program relieved before the completion of his period of obligation may, under regulations prescribed by the Secretary of Defense, be assigned to an area of health manpower shortage designated by the Secretary of Health, Education, and Welfare until the completion of his period of obligation.

"§ 2124. Members of the program: numbers appointed

"The number of persons who may be designated as members of the program for training in each health profession shall be as prescribed by the Secretary of Defense, except that the total number of persons so designated in all of the programs authorized by this chapter shall not, at any time, exceed 5,000.

"§ 2125. Members of the program: exclusion from authorized strengths

"Notwithstanding any other provision of law, members of the program shall not be counted against any prescribed military strengths.

"§ 2126. Members of the program: service credit

"Service performed while a member of the program shall not be counted—

"(1) in determining eligibility for retirement other than by reason of a physical disability incurred while a member of the program; or

"(2) in computing years of service creditable under section 205 of title 37.

"§ 2127. Contracts for scholarships: payments

"(a) The Secretary of Defense may provide for the payment of all educational expenses incurred by a member of the program, including tuition, fees, books, laboratory expenses, and payments for educational services. Such payments, however (other than those for educational services), shall be limited to those educational expenses normally incurred by students at the institution and in the health profession concerned who are not members of the program.

"(b) The Secretary of Defense may contract with an accredited civilian educational institution for the payment of tuition and other educational expenses of members of the program authorized by this chapter. Payments to such institutions may be made without regard to section 529 of title 31.

"(c) Payments made under subsection (b) shall not cover any expenses other than those covered by subsection (a)."

(2) By inserting the following new items in the chapter analysis of subtitle A, and the chapter analysis of part III of subtitle A:

"104. Uniformed Services University of the Health Sciences.

"105. Armed Forces Health Professions Scholarship Program."

(3) By amending sections 3202(e) and 8202(e) by striking out "in grades below brigadier general" and insert in place thereof "in the various grades".

(4) By amending section 5793 by striking out "in grades below rear admiral" and inserting in place thereof "in the various grades".

Passed the House of Representatives November 3, 1971.

Attest:

W. PAT JENNINGS, Clerk.

Senator BYRD. H.R. 2 contains three major provisions:

First, H.R. 2 provides the authority for the establishment of a uniformed services university of health sciences which is intended

to be a medical school and include such other military allied medical specialties as might be added. The total cost of establishing the university over a 10-year period is estimated at \$101.7 million. I hope at the appropriate time we can have a little discussion of that figure.

Second, H.R. 2 provides for a medical scholarship program under which scholarships would be granted for civilian medical schools to those who would agree, upon completion, to serve at least 1 year for each year of training received. The scholarships would be in the form of payment of all medical school expenses. In addition, a student would be appointed an O-1 2d lieutenant, thereby receiving the pay and allowances for that grade while in medical school.

The scholarship program is projected to cost in the range of \$40 to \$50 million per year.

Third, H.R. 2 removes medical and dental officers of general or flag rank from all statutory numerical limitations. The Chair is not just clear as to why that should be. We can get into that a little later.

I would like to comment briefly now on this shortage in the United States today of manpower in the health sciences. This fact is indisputable. The President of the United States has recognized this and so has the American Medical Association. The Carnegie Commission on Higher Education, in its report of October 1970, spoke of "an acute shortage" of physicians in the United States today.

This situation, of course, seriously affects the military. During the last 4 years, fully 60 percent—and to me that is an astonishing figure—60 percent of the male physicians graduating from medical school have entered military service, yet the retention rate for physicians is only about 1 percent of those who are drafted for 2 years of service.

Of course, the military has been able to obtain the necessary medical personnel for its requirement through the so-called doctor draft law. However, now that the President has announced cancellation of all future undergraduate student deferments, all college students will be vulnerable to the draft on a one-time basis. The result of this will be elimination of the effect of the doctor draft within 6 years. The dramatic impact that this will have on military medical services in the years to come is obvious.

With this as a background, I am more than happy to welcome you, Dr. Wilbur, to hear your testimony on this legislation of vital concern to the military services and the Nation. I am also happy to welcome the Surgeon General of the three military departments: Lt. Gen. Hal B. Jennings, Jr., Surgeon General of the Army; Rear Adm. David P. Osborne, Assistant Chief of the Bureau of Medicine and Surgery for Personnel and Professional Operations; and Maj. Gen. Thomas H. Crouch, Deputy Surgeon General of the Air Force.

Dr. Wilbur, you may proceed as you wish.

STATEMENT OF HON. RICHARD S. WILBUR, M.D., ASSISTANT SECRETARY OF DEFENSE, HEALTH AND ENVIRONMENT, ACCOMPANIED BY LT. GEN. HAL B. JENNINGS, JR., SURGEON GENERAL OF THE ARMY; REAR ADM. DAVID P. OSBORNE, ASSISTANT CHIEF OF THE BUREAU OF MEDICINE AND SURGERY FOR PERSONNEL AND PROFESSIONAL OPERATIONS, USN; AND MAJ. GEN. THOMAS H. CROUCH, DEPUTY SURGEON GENERAL, U.S. AIR FORCE

Dr. WILBUR. Thank you very much, Mr. Chairman and Senator Bentsen.

I am, as you stated, Dr. Richard S. Wilbur, the Assistant Secretary of Defense, Health and Environment. I have been designated to represent the Department of Defense during these hearings on H.R. 2. As you also stated, I am accompanied today by Lt. Gen. Hal B. Jennings, Jr., Surgeon General of the Army; Rear Adm. David P. Osborne, Assistant Chief of the Navy's Bureau of Medicine and Surgery for Personnel and Professional Operations; and Maj. Gen. Thomas H. Crouch, Deputy Surgeon General of the Air Force.

The purpose of H.R. 2 is to provide the legislative basis for programs to assist the Department of Defense in overcoming the critical shortage of career-oriented military personnel who are qualified in the health professions. The Department of Defense fully supports the purpose of H.R. 2. In addition, we support the specific provisions of the bill, with one exception. The exception covers the provisions, which you noted, that would lift restrictions on authorizations to flag ranks.

Senator BYRD. If I can interrupt there, you mean you oppose that?

Dr. WILBUR. We oppose it as it is currently written; yes, sir. We would like to come back on the basis of previous discussions we have had with Senator Stennis, chairman of the committee, with a different proposal.

Senator BYRD. Thank you. I didn't mean to interrupt you.

Dr. WILBUR. In recent years the Department of Defense has experienced critical shortages of career-oriented military members of certain health professions, particularly the professions of medicine and dentistry. To meet our needs for qualified personnel in these fields, we have relied heavily on the Selective Service System; in fact, even most of our so-called voluntary procurement programs for physicians and dentists have been based upon the fact that most members of these professions could either serve voluntarily in an armed force of their choice or they would be allocated to an armed force under the so-called doctor draft.

We are now in the process of moving from a military force that is heavily supported by conscription to an all-volunteer force. In view of past difficulties in obtaining volunteers in the health professions, we expect that, without substantial change in our procurement program and in the professional career we can offer members of the health professions, our greatest obstacle to an all-volunteer force will be in obtaining members of the health professions. We have concluded that we cannot justify the drafting of health personnel only. Accordingly, we must have revitalized programs to assist us in meeting our minimum requirements for health personnel. We believe that a Uniformed

Services University of the Health Sciences and an Armed Forces Health Professions Scholarship program are such programs.

One of the greatest difficulties that we anticipate in procuring health professionals is in persuading members of the professions to even consider a career in the Armed Forces. The scholarship program contained in H.R. 2 could greatly assist us in overcoming this difficulty.

Each of the military departments has presently a limited program similar to the scholarship program envisioned by H.R. 2. These limited programs have been highly successful, and it is our hope and our belief that a large program established by law would meet with equal success.

If H.R. 2 is enacted, we would attempt to enroll approximately 1,800 medical and dental students in the scholarship program during the first fiscal year at an estimated cost of \$20 million. We would expand the program until by the fifth fiscal year we would have approximately 3,300 students in the health professions enrolled in the program. Thus we would expect that for the short range the scholarship program would be the major device used to fill the procurement gap created by the expiration of the doctor draft.

While the scholarship program would be considered as the primary procurement device, we would look to the Uniformed Services University of the Health Sciences as a long-range device for retaining the members of the health professions whom we do procure. We would expect it to give the Department of Defense access to the many benefits of academic medicine.

Since World War II, knowledge in the health professions, as in any other scientific field, has progressed at an awesome and accelerating rate. No longer can the graduate of a medical or dental school consider himself equipped for the indefinite future for the practice of his profession. He must constantly remain in touch with and periodically return to the learning environment to keep pace with new developments in his field. The conscientious health practitioner will not commit himself to a program that does not give him adequate opportunity for continuing education.

The military departments have attempted to provide opportunities for continuing education but have been seriously handicapped because, in most cases, they have had to rely on external programs. A university operated by the uniformed services would make continuing education an integral part of the military medical services and give military health practitioners adequate opportunities to participate in continuing educational programs in all roles.

In addition to the direct benefits of the university to the continuing education of our health professionals, we would be able to harness the vast medical resources of the Department of Defense that are located in the Washington, D.C., area. As students graduated from the university, we would be able to reduce our demands on civilian institutions.

As I mentioned earlier, we do not favor eliminating the restriction on officers in the flag ranks at this time. While we favor the concept of providing greater rewards for our clinical physicians and dentists, we do not believe that our needs can best be met by the amendments contained in H.R. 2.

The Department of Defense is currently reviewing the matter of the status of these clinicians, and we recommend that no action be taken on this subject until we have fully evaluated our findings.

In summary, it is the position of the Department of Defense that amendatory language to existing laws is necessary in order for us to provide sufficient members of the health professions to meet our medical responsibilities in an all-volunteer Armed Force. A Uniformed University of the Health Sciences and an Armed Forces health professions scholarship program similar to those contained in H.R. 2 would greatly assist us in achieving our goals, and we strongly urge that they be favorably considered by this subcommittee.

I appreciate this opportunity to appear before the subcommittee. With the assistance of the Surgeons General, I shall be happy to answer any questions you have regarding the health programs of the Department of Defense.

Senator BYRD. Thank you, Dr. Wilbur.

I have a number of questions. I will ask a few and then I will yield to the Senator from Texas, and later ask the remainder of the questions.

Now my first question: I think that you have already commented on that: You would propose to change the present bill which would eliminate the present statutory restraints on the promotion of medical and dental officers to flag and general officer rank. You might comment a little more on that but, as I understand it, you have already volunteered that you would prefer to eliminate that section?

Dr. WILBUR. Yes, sir; we would.

We would prefer to come in later with another bill that will deal with this concept in a different way. At the present time it is very difficult for a man who wishes to be a clinician throughout his entire career in the service to stay on working with patients as is usually done in civilian life. In order to advance in prestige and status and, to be perfectly honest, to increase his take-home pay, he must go into the executive part of medicine. He must become a hospital commander or he must work on the staff of a large headquarters.

This has occasionally caused a very good surgeon to become a rather mediocre executive which is not fair to the service nor particularly, of course, to the man himself. What we are considering is a concept under which there would be two forms of advancement for a physician or dentist in the service: One, where he does go into executive medicine or dentistry, a very necessary part represented by the men here with me; the other would permit those men who wish to take care of patients through their whole career to achieve flag rank and yet continue their direct patient care duties.

We, however, feel that the specific way it is presented in H.R. 2 won't achieve this in the best fashion. Therefore, we would very much prefer to come back with separate legislation later.

Senator BYRD. So, to be clear, you would eliminate that from this present legislation?

Dr. WILBUR. Yes, sir.

Senator BYRD. And you will come back later with suggestions?

Dr. WILBUR. Yes, sir; as soon as our proposal is cleared within the executive branch.

Senator BYRD. So far as the present legislation, H.R. 2, is concerned, that part of it would be eliminated; is that your recommendation?

Dr. WILBUR. That is our recommendation; yes, sir.

Senator BYRD. Would you describe in some detail the present military expertise and facilities in the medical sciences which would help in this establishment of a Uniformed Services University of the Health Sciences?

Dr. WILBUR. Yes, sir, and should I need assistance I will call upon my colleagues, if I may.

We have within the Washington area three large hospitals—Bethesda with the Navy, Walter Reed with the Army, and Andrews with the Air Force. We have the Armed Forces Institute of Pathology which has been in existence for a century and is world renowned for its ability in pathology. All of these presently have some form of postgraduate teaching program. Obviously, they are not coordinated as they would be within a university framework.

We have also scattered throughout the rest of the country places such as Wilford Hall, the Air Force hospital near San Antonio; and other teaching hospitals, that have within them excellent men, men of teaching caliber.

We have been distressed within the last few years to lose from the service, to the universities of this country, men who are taken in as senior professors, who leave the armed forces, not because they are unhappy with us, but because of their interest in academic life.

The civilian medical schools of this country seem to think we have men within our ranks who are capable of being professors. We agree with their judgment.

Senator BYRD. You mentioned that you have three hospitals in this area?

Dr. WILBUR. Yes, sir.

Senator BYRD. Army, Navy, and Air Force. The university that you are speaking of would be a one-service university, I assume, or a multi-service?

Dr. WILBUR. No, sir; the concept is multiservice. Yes, it would consist of all three services working together. It is very common within civilian medical schools to use a number of different teaching hospitals for one university.

Senator BYRD. Where would you obtain the faculty for such a university?

Dr. WILBUR. As I had indicated previously, we find our ranks being raided by the civilian universities, so we are quite certain that we have such men, and we can identify in the Armed Forces Institute of Pathology and other places men of obvious academic quality, but it would be important for it not to be a totally military medical school. It would be important to obtain some of our professors, some of our teachers from civilian ranks as well.

Senator BYRD. You would seek to strike a balance between civilian and military faculty members?

Dr. WILBUR. Yes.

Senator BYRD. How would you answer the charge of parochialism leveled against the establishment of a military medical university? Would the peculiar medical requirements of the military sooner or later isolate such a university from the mainstream of civilian medical universities, would you think?

Dr. WILBUR. I think there would be such a danger and I think it would be one which we would have to face directly, to meet, and to

make very certain that we did have constant interchanges with civilian universities.

It would be a vast mistake if military medicine were to divorce itself from civilian medicine. At the present time, as you pointed out, almost 60 percent of the men who have been through medical school in the last few years have been through the military, which has allowed for an interchange both ways, military to civilian and civilian to military; so we have benefited from this interchange.

If I may add to this; for instance, in the recent problems we have had with drug abuse, it has been of tremendous help to us that many of the men who came into the service came from areas where they faced this problem in civilian life; they were of enormous benefit to us.

We cannot isolate ourselves from the benefits of civilian medicine, both academic and clinical.

Senator BYRD. What size medical school would you envision?

Dr. WILBUR. One sufficient to graduate 100 medical students per year within 10 years.

Senator BYRD. What faculty would that require?

Dr. WILBUR. The question is a difficult one to answer because so much of what a faculty of a medical school does is not directly involved with teaching, that is, many of the people on the faculty spend a great deal of their time in clinical work and only, for instance, a portion of their time taking medical students around and seeing patients.

I think what you are asking is how many above what we already need to run our excellent teaching institutions here, how many additional. I think I have it by costs rather than by actual numbers of faculty.

We feel that the costs over and above what we would need for just operating the present hospitals would come to around \$20 million a year. I give it to you in terms of dollars instead of personnel. We feel with a lot of half jobs—

Senator BYRD. Where do you get the figure of \$100 million as the cost of your medical school?

Dr. WILBUR. These are the startup costs over a period of 10 years. It includes some \$32.5 million of construction costs. The remainder of this is in what it would cost in operations and maintenance over and above what we currently pay to operate the three teaching hospitals in the area.

I have a breakdown of our preliminary budget estimate which we can furnish to you.

Senator BYRD. I am trying to understand how firm or how accurate that estimate might be.

Does it include an inflationary factor?

Dr. WILBUR. It includes an inflationary factor of about 5 percent in construction. Since we have developed these figures we found that at least for the last 2 years it would have been more accurate to have used 6 percent, which would raise the cost by another \$1 million. The factor of about 4.5 percent annually for salaries, which is what we used, seems to be in line with what has happened in the last couple of years.

Mr. Chairman, when you are estimating something that is going to happen 10 years away, the only thing you can be sure of it is going to be something else; but this is our best general estimate.

Senator BYRD. Well, what comparisons have you made with costs of civilian medical schools to determine this figure?

Dr. WILBUR. Most of these figures have been derived from civilian experience.

Senator BYRD. Where would you plan to locate this school?

Dr. WILBUR. H.R. 2 specifies that it would be within 25 miles of Washington, D.C. We haven't any exact spot in mind. One presumes that it would be somewhat contiguous to one of the existing major hospitals—Bethesda or Walter Reed.

Senator BYRD. What interservice problems would that cause?

General JENNINGS. I see none particularly because these are clinical facilities; where we have actual live patients. The other part of the university would be didactic. The university would send its students to any one of the three to get their actual clinical experience with patients. Whether we send them to Bethesda, Walter Reed or the Air Force Hospital at Andrews would not pose any significant problems for us.

The students that come out of the university would be divided among the three services. Our purpose would be to turn out a good product and our teaching goals are the main thing; so I see no problem on it so far as I am concerned in any of our facilities.

Senator BYRD. You plan on turning out 100 doctors a year; is that right?

Dr. WILBUR. That is what is proposed in the legislation; yes, sir—100 medical school graduates.

Senator BYRD. One hundred medical school graduates, is that a better way of expressing it—100 medical school graduates a year?

I am just concerned about that overall figure. It seems to me that is going to be probably a pretty low figure when you talk about facilities, that will be adequate facilities, because if it is not going to be a good medical school you are better off not to have it, I guess?

Dr. WILBUR. Yes, sir; you are absolutely right.

I would like to emphasize what you say. For the military to set up a second-class medical school and give the impression to the world that military medicine is second-rate would destroy everything we are working toward.

Senator BYRD. I think it would.

Dr. WILBUR. You are absolutely right.

Senator BYRD.

Norfolk, Virginia, is considering starting a new medical school and I have had some little knowledge of that; and the cost is going to be tremendous. I don't recall the figures at the moment. I would like to ask the staff if they would remind me to check on those Norfolk figures to see how they compare with this estimate. I think it is just about the same size school or a little smaller school, if my recollection is correct.

Senator BENTSEN?

Senator BENTSEN. Thank you, Mr. Chairman.

Dr. Wilbur, I wholeheartedly agree with your one statement about your exemption from the bill concerning the question of the advance to flag rank. The fact that a man is a great surgeon certainly does not make him a great manager. They obviously are not the same skills. The fact that a man is a great manager, of course, would not

make him a great surgeon; and a way should be found to award each for those talents and not require them to be intermingled.

You made a statement in your testimony that the limited scholarship program had been highly successful. Now, I know that 60 percent of the graduates have entered into military service and yet there is a 1 percent or less retention; isn't that right?

Dr. WILBUR. Yes.

Senator BENTSEN. You say the male physicians entering military service is 60 percent, yet the retention rate for physicians is only about 1 percent?

Dr. WILBUR. Yes, sir, but we are speaking of two different groups.

Senator BENTSEN. I understand we are. I want your figures on the particular group you are talking about. You gave us none of those. I wanted to know why.

General JENNINGS. In the Army, the doctors that we have drafted who come in for 2 years' service, we have only been able to retain one percent of those as what we term career doctors. Those doctors that have voluntarily applied for our residency, our training programs, become specialists and go through our teaching programs as such. We have retained 25 percent of those, so those people that we have exposed to our good product, we have retained 25 percent of those, had them for a longer period of time and shown them the academic side of medicine and what we can produce and how we do that.

The doctors that come in under the draft and have had to go into the Vietnam war and go to these turbulent assignments, and so forth, have not been exposed to what military medicine is really all about and we have only retained 1 percent.

Senator BENTSEN. Now, this group that you referred to where you have a 25-percent retention, and you advised me as to the type of training—does that mean the scholarship group?

General JENNINGS. This includes the scholarship group.

Senator BENTSEN. Will you break out the scholarship group for me?

General JENNINGS. I do not have those figures. I can supply those to you.

Senator BENTSEN. Because I think only then do we know what we are really comparing.

General JENNINGS. The scholarship program is very small. We are militarily, as far as doctors are concerned—I only have 38 doctor scholarships available to me at the present time so it is a very small figure and it may not be a representative figure; but I can supply those figures to you.

Senator BENTSEN. When you say "to you" you mean just for the Army?

General JENNINGS. Just to the Army.

Senator BENTSEN. Do you have a different feel for that?

General CROUCH. Sir, we have only been in the fully sponsored scholarship program where we sponsor the student through all 4 years of medical school for just 2 years; therefore, we do not have any experience factor on how long they will remain with us. Our experience mirrors those in the Army in those who have been trained in specialties after coming into the service from the civilian medical schools. Our retention rate has been from 25 to 40 percent, depending on the specialty. Obviously, those who have been trained in aviation medi-

cine stay in the Air Force longer than those who have been trained in obstetrics or pediatrics.

Senator BENTSEN. Then, Dr. Wilbur, your statement that the limited scholarship programs have been highly successful—at this point you do not have any numbers to back that up?

Dr. WILBUR. Beyond what you have already heard; no. They are limited programs, as we have pointed out, but we shall present you with more detailed figures than we have with us at the minute.

I think in addition to the answer we should point out that we are also very aware our retention problems are severe and we will be coming in with a program which speaks to that problem. Our presentation today deals primarily with procurement.

Senator BENTSEN. It seems to me by far the major problem is the retention problem and the one that requires the very highest of priorities on the part of the Defense Department.

Now, you have made the statement that the Department of Defense would have access to the many benefits of academic medicine. Is the reverse true? Are you saying that you do not have access to the benefits of academic medicine at the present time when you have scholarships to give and, in effect, rewards to give to these many medical schools?

Dr. WILBUR. At the present time our scholarship program is very limited; we would like to expand it; and that is why we are here today. The academic benefits about which we speak accrue to them as part of the retention. As I was saying earlier, we have lost many of our excellent men to academic institutions because they can't have academic status or have difficulty having academic status while they are in the military and because they wish to teach they leave us for civilian institutions.

Had we such a university, these men would be far more likely to stay with us.

Senator BENTSEN. Why don't you have a program like the State Department? The State Department, when you have a man who has been on tour for a period of time and you want to give him a sabbatical, they have a program where they can send him to a university and he doesn't lose his status with the State Department and he can choose a university almost of his choice and go down and teach for a period of 9 months and that is a real refresher.

Dr. WILBUR. That is my other package that I will be back with later—my retention package, Senator. I am very delighted you mentioned that because that will be of help to me. Yes; I propose to come up with just that sort of a plan.

Senator BENTSEN. I would have more enthusiasm for that than I have for this.

Senator BYRD. Would the Senator from Texas yield?

If you are coming up with another program, an additional program, I am wondering whether all these programs should not be considered together rather than separately?

Dr. WILBUR. We would hope you would consider this one at the present time which has to do with procurement; whereas, as I said, the other is keeping people within the service which has to do partly with pay, but also as to do with reconstruction of facilities to enable us to be more efficient. It has to do, as Senator Bentsen was pointing out,

with continuing medical education, both some that we would provide every year for a man and also the sabbaticals to which you refer. It is a different package in a different part which comes under our manpower and our all-volunteer force budget.

The reason we would very much like to have the procurement now is because we are hopeful of offering these scholarships to men currently for this year in school and we would hate to delay any longer because the year is now virtually half over.

We still have hopes, and we still have plans—we have men ready to go out as soon as, and if this is passed, who will attempt to enroll men even for the last half of the year.

Senator BYRD. Thank you, Senator Bentsen.

Senator BENTSEN. Now, you make another point in your testimony that you want to reduce the demand on civilian institutions. There are some of us who feel, with the high percentage of support troops and personnel as related to combat troops, that maybe the reverse should be taking place, that maybe you should be increasing your demands on civilian institutions and there should be a reduction of service people in the defense forces?

Dr. WILBUR. First, we are planning for a reduction in the number of military physicians; second, though, it is impossible for us to make demands upon the civilian practice of medicine at such a time as the figures of a shortage, of 50,000-physician shortage in civilian life—I can't swear to those figures, but there are many people today who feel we are very short and who would like to get a doctor but can't get one.

The thought behind this is that it is wrong for us to demand a man leave civilian practice for the military—if we could be training him ourselves, we could be helping to produce physicians rather than to depend solely upon civilians.

Senator BENTSEN. Dr. Wilbur, I had a number of questions about retaining doctors in the medical service and what is to be done to make the career more attractive but apparently that is in the forthcoming chapter—

Dr. WILBUR. Yes, sir.

Senator BENTSEN (continuing). Or presentation?

Dr. WILBUR. You stated they should be of the highest priority and I assure you they are, and I am sure these gentlemen would support me, as we were discussing among ourselves just before you came in.

Senator BENTSEN. Let me dwell a little more on this point of getting to a situation where you get a stereotyped education or you get a conformity.

It seems to me that you get some crosspollenization in receiving doctors from many medical schools and that this is a contribution; this is helpful. I am much more interested, frankly, in the scholarship program than I am in your having a university that is dedicated just to the military. I don't see that much uniqueness in the military practice.

Dr. WILBUR. It would be our hope that this would be very little different from civilian practice. As I was saying in response to a question from the chairman, it would be a mistake for us to set up a separate type of medicine. We have a few parts that are separate—high altitude, low altitude, high pressure—the things that come with the unusual parts of military medicine. These really do not enter

into the undergraduate training; these are really things almost totally in the postgraduate field after a man has gotten out of medical school.

Senator BENTSEN. Mr. Chairman, I have no further questions. Thank you very much.

Senator BYRD. Thank you, Senator Bentsen.

Senator Schweiker?

Senator SCHWEIKER. Thank you, Mr. Chairman.

As I understand it, doctor, there is a study you folks are making which is due on the 29th of March?

Dr. WILBUR. Yes, sir.

Senator SCHWEIKER. Now, I would think that would have a great bearing on what our committee would do. Is any of your statement based on what the study is going to show or at this point is the study not widely available, that you are incorporating that into what you are saying here?

Dr. WILBUR. The study to which you refer, of course, is the one which is required by the Kennedy amendment, to Public Law 92-129, the so-called draft extension law. It requires the Department of Defense and HEW to jointly look into the feasibility of turning over some of our military medical workload to civilian hospitals and physicians.

Our preliminary look at this reveals that if the Federal Government is willing to pay the cost, there are a number of areas in which a significant portion of our military medical workload could be diverted to the private sector.

There is no way we can see transferring so much of this care that we would not require a sizable military medical force under the all-volunteer concept and to obtain this we must have some form of procurement other than the draft.

Currently the doctor draft is expected to end by the middle of 1973 and we are working to meet that deadline. There are certain areas, Senator Schweiker, in which it is just impossible to civilianize care. We have people—men on active duty and their dependents—located in areas in which there is no civilian care. We have areas such as Travis Air Force Base in California where the local mayor and Representative Leggett, who represents that area in the House, are asking the Air Force hospital to send down Air Force doctors to help take care of the civilian community. There is no way in which we can transfer some of the military responsibility to the civilians in that area because they can't handle what they already have.

So we feel that we will not be able to drastically reduce the size of the medical force.

Senator SCHWEIKER. Who—you folks are making the study internally—is responsible for that study?

Dr. WILBUR. One of my deputies, Vernon McKenzie.

Senator SCHWEIKER. And it will be out on that date hopefully or what?

Dr. WILBUR. Yes, sir. The study will be forwarded to the Congress by March 29.

Senator SCHWEIKER. Because I think it would be very helpful to this committee to see that.

The next question deals with another study that the GAO made, that I am sure you are familiar with, on December 16, and just high-

lighting this study of medical utilization, medical personnel, I just want to read a few of its findings from GAO:

Many physicians, dentists and nurses fill staff and administrative positions in the Office of the Surgeon General and in intermediate commands of the three services. In some positions the officers' medical professional abilities are used only part time. Fewer medical professionals would be needed for staff, administrative and management positions if these positions were centralized under the Assistant Secretary of Defense, Health and Environment. ment.

The medical professionals could be used as consultants to make medical decisions. Medical professionals assigned to treatment facilities could give more time to patient care if command, administrative and nonprofessional duties were assigned to qualified nonprofessional personnel.

Now, obviously, their study shows there is, according to their understanding, a misuse of our medical manpower we have; and I am sure you are familiar with the report and I wonder what some of your reactions are to the report.

Dr. WILBUR. I believe that some of the things they point out are true. I have discussed this with the Surgeons General. We are reviewing this. All of the Surgeons General have come up with positive responses, that is, that there are some positions of that type, the administrative type, which can be eliminated. Others can be reduced. We believe that if we are allowed to have more clerical help for many of our clinical doctors out in the field that we will be able to reduce the amount of time spent on paperwork, that is, increase the amount of time spent on patients and reduce the number of positions.

But we are now talking about 14,500 physicians and I am speaking not of dentists and all, although they are in the scholarship program, but I am just making one point to make a clear example.

Even if we were to agree that every one GAO identified as being extra was indeed extra—and we don't so agree—we would still have a very serious problem and it would still require these scholarships to fill our ranks within the next few years.

Senator SCHWEIKER. Well, as you probably also know, they come up with about 10 specific recommendations that the Secretary of Defense should take on assignment, utilization, and I just wondered how feasible you felt, without going into detail, how feasible these 10 recommendations were, in your judgment?

Dr. WILBUR. I don't have them before me, but I recall several of them.

One had to do with rooms per dentist and I thought that was an extremely good one.

Senator SCHWEIKER (reading):

Consider assigning nonmedical personnel to administrative and management positions at the headquarters levels in Washington, D.C. in an organization under the Assistant Secretary of Defense (Health and Environment) and using medical professionals as consultants for making medical decisions.

Another one is:

Begin a program to place Medical Service Corps officers with masters' degrees in hospital administration into positions as hospital commanders.

Expand the program for acquiring, training and educating physicians assistants and ancillary and supportive personnel and create enlisted and officer career grades in specialty categories for these personnel.

I don't want to read them all, but I think they give you a pretty good idea that they feel there is a lot that can be done in terms of just the way we utilize the medical personnel we have.

Dr. WILBUR. The ones you suggest—for instance, the placement of Medical Service Corps officers as commanders of treatment facilities is being done by the Air Force at the present time.

You speak of the physician assistant program. All three services are developing such programs. However, we won't have the first graduates from these programs for about another 18 months. At that time they will replace a certain number of physicians. My memory is that in 5 years they will replace 264 physicians with the present program.

Yes, sir; many of the suggestions they make are good ones; we are already engaged in implementing some of them.

Senator SCHWEIKER. It also refers here to taking action on the recommendations made in recent contractor studies for improved productivity of professional and nonprofessional dental personnel.

I wonder if you had any reaction as to their suggestions that we act on this previous contractor study about utilization of dental personnel?

Dr. WILBUR. A very positive reaction. One of the things they pointed out is that we don't have enough dental assistants per dentist. We don't have enough rooms per dentist. We are in agreement with this.

It all comes down to the same thing: We need more money for more rooms for each dentist and for the dental assistants, more room, and in that latter case more training. We are in agreement with this. It is a little slow to implement because of the building required. We will be coming back to you on this subject when we present our retention package.

One of the portions will deal with more facilities and with more assistance, just exactly what GAO has recommended.

Senator SCHWEIKER. There has been some talk—I know because I am also on the health subcommittee and labor subcommittee—some talk that the Public Health Service may give up or close its Public Health Service hospitals and clinics. I just wonder if you folks had considered any possibility of utilizing these people and facilities and work? In other words, here is a ready, tailor-made facility that one phase of government seems to want to get out of—I know it is controversial—but assuming they did, have you folks given any consideration to the possibility of picking up these facilities here for military use?

Dr. WILBUR. Secretary DuVal did visit my office and talk to me about this. But he also wanted us to take on their missions and, frankly, as far as manpower is concerned, it was going to be a negative for us; that is to say, we would require more manpower if we were to perform all of their missions.

Senator SCHWEIKER. Yes; I was asking that question about missions. I appreciate that.

Dr. WILBUR. I am not saying we won't do it. We are looking at this. For instance, in taking care of the Indians in Alaska if the current Public Health Services were to disappear, there may be some ways in which military facilities in that area could take on this mission, but that would simply increase our need for manpower, not decrease it.

The facilities to which you refer are six Public Health hospitals.

Senator SCHWEIKER. If you take on the missions, though, my ques-

tion did not assume taking on the missions but my question was if you pick up the facilities, not the missions. This is on the assumption they are phasing the missions out.

Dr. WILBUR. I am not sure, sir, that that is a valid assumption; at least it was never presented that way to me by the Department of Health, Education, and Welfare, that the mission, for instance, to take care of the Indians, would be phased out.

Speaking to the facilities, most of them really would not be helpful to us. We have a lot of in-hospital beds; we always had more than we actually are using because the military, like the fire department, must be ready for sudden troubles.

Beds are not our problem; it is the people, the manpower problem; that is what we are speaking to now. Where we have a shortage of facilities is in our outpatient departments and the Public Health Service facilities really would be of little or no value to us in this regard.

Senator SCHWEIKER. What I was assuming there would be that you would work out some arrangement whereby you pick up the medical personnel of the Public Health Service. In other words, there is a serious proposal before our committee to just plain cut them loose, turn them out and that it is controversial. My point was whether we had given consideration to bringing them in in some useful capacity, for your services in some way that would be meaningful in some way, retrain their personnel and skills and obviously change their mission.

It just seems to me here is a vast reservoir of medical skills and personnel that one group in Congress is considering shutting down, who are now Federal employees.

Dr. WILBUR. Now you are getting me a little beyond what I came prepared to speak to, but I have talked to Dr. DuVal about this. The main reason that they are considering discontinuing the commissioned officers corps is that with the end of the doctor draft they will not be able to get a sufficient number of physicians. In other words, their problem is the same as ours except actually their retention rate, if anything, is a lower one, smaller than the one Senator Bentsen was concerned about with the military and this would not be of value to us because these people are also in for only 2 years.

There are some senior members of the Public Health Service Commissioned Officers Corps in their 40's and 50's but they are relatively a small number of people and, as I understand it, they were to be kept within the Department of Health, Education, and Welfare with or without uniform.

Senator SCHWEIKER. Well, this is still being debated before our committee so it is very much up in the air.

Dr. WILBUR. You are ahead of me on that.

Senator SCHWEIKER. That is all I had, Mr. Chairman.

Senator BYRD. Thank you, Senator Schweiker.

May I ask General Jennings, General Crouch—either or both—whether you are West Point graduates?

General JENNINGS. No, sir.

General CROUCH. No, sir.

Senator BYRD. One of the greatest of West Point graduates is having a birthday today. He is also one of the five or six greatest Vir-

ginians, Gen. Robert E. Lee, and there is a ceremony in the Capitol right now at 11 o'clock and may I ask Senator Bentsen if he would take charge at this point and permit me to do honor, give respect, to General Lee? I will be right back.

Excuse me, gentlemen; I will be right back.

Senator BENTSEN (presiding). Very well, Mr. Chairman.

Dr. Wilbur, in the utilization of the scholarship program, would there be any attempt on the part of the Defense Department to monitor or to set standards for those who were granted the scholarships, and then monitor their performance as they proceeded through school?

Dr. WILBUR. Yes, sir; although the majority of the monitoring would, of course, be by the civilian medical school itself, that is to say, the standards of academic performance.

Senator BENTSEN. How would a new program of scholarships relate to the present small programs that you have? Would you phase those out or would they be merged?

Dr. WILBUR. Because our need is so great, we intend to continue to operate our present programs.

Senator BENTSEN. It has been indicated that if H.R. 2 is to become law that the total number of scholarships for 1972, fiscal 1972, would be 1,800 at an annual cost of \$20 million. Does that mean if the scholarship program starts in the middle of the year that the first year of costs would be around \$10 million?

Dr. WILBUR. No, sir. Each day we don't implement this, the figures change; I don't know how many men would actually take it in mid-year. No, sir; that figure of \$20 million was on the basis that we were starting, I believe, in November. It would be less now.

Senator BENTSEN. Now, of course, Senator Goldwater has introduced S. 853 and there are many similarities. Are there any major differences between his bill and H.R. 2?

Dr. WILBUR. No; there are very small differences between his and ours.

Senator BENSTEN. This particular bill limits the scholarship to 4 years and a number of the medical schools are considering variations in the period of time of the curriculum, varying all the way from 2 to 6 years.

Would it be undesirable to put an arbitrary ceiling on the period of time for a scholarship?

Dr. WILBUR. Yes, I think that is a modification that should be considered. Obviously, the shorter periods would not concern us as much.

Senator BENTSEN. What contingencies do you have for students who failed to live up to the scholarship requirements?

Dr. WILBUR. We would still expect those people who were no longer going to progress to become a physician—we would still expect them to join us in the service and to pay us back their obligated period, obviously not as a physician but most of them would presumably be interested in the health field and could join our medical service corps or whatever they are qualified for by the amount of training they have had and by their ability.

In general, a man who can be admitted to medical school has some abilities that we could use.

Senator BENTSEN. Senator Schweiker, do you have any further questions?

Senator SCHWEIKER. Yes; thank you, Mr. Chairman.

Dr. WILBUR, let me understand a little more about the costs estimate that you folks have made here. It is \$100 million will give us what in terms of a school of medicine and in terms of scholarships and interim proposals and the like?

Dr. WILBUR. No, sir; the school and the scholarship program are two different things.

Senator SCHWEIKER. All right.

Dr. WILBUR. The scholarship estimates are totally different from this estimate.

Senator SCHWEIKER. They are not included in that?

Dr. WILBUR. No, sir; these are two separate things.

Senator SCHWEIKER. All right.

Dr. WILBUR. Which would you like?

Senator SCHWEIKER. I am interested in the cost of the school of medicine and what you feel you will need to operate it.

Dr. WILBUR. Our belief is that it would cost us, over and above present expenditures, for the first 10 years about \$101 million, closer to \$102 million, which is an estimate.

Senator SCHWEIKER. Now that would include physical construction of this facility, too, right—capital?

Dr. WILBUR. Yes, sir.

Senator SCHWEIKER. And then it would assume an operating, yearly operating deficit or cost of about what? Part of it is capital and part of it is yearly operating. I wonder if you could give me a breakdown of that?

Dr. WILBUR. Yes.

Yearly operating costs would go up from about \$327,000 the first year to about \$21 million by the 10th year.

Senator SCHWEIKER. How much of your \$101 million, \$102 million, would be for capital investment in the school?

Dr. WILBUR. About \$35 million.

Senator SCHWEIKER. That sounds awfully low to me. Again, Penn State just got a new in-State medical school, courtesy of Hershey Chocolate Foundation, and they donated the whole school from scratch to finish, and this was 3 or 4 years ago, and it cost \$66 million. They are going to graduate first of all 60 doctors every year and then a capacity of 120, which is what you are talking about. It cost them \$66 million from scratch a few years ago and that is not counting operating deficit, so when you talk about operating deficits, if I understand you right, of \$21 million a year, whatever it might be, I just wonder if we are on target because I understood the Penn State costs were pretty comparable.

I think it was a new medical school built, I believe, in Arizona—I am not sure where—that was very comparable in costs to this and it seems to me your costs are half of what the medical school costs are we are putting up around the country.

Dr. WILBUR. The greatest cost of any new medical school is a hospital and in this case we are assuming we would use the existing hospital facilities, Walter Reed, Bethesda, and Andrews, and that this would save the great majority of the costs. This money includes only about \$2.5 million for additional clinic facilities at those hospitals for teaching purposes; that is to say, less than \$3 million for what you might

call hospitals; and all the rest of the \$35 million would be for the academic and school part, and this is a tremendous saving, of course.

Senator SCHWEIKER. I would agree the training, the training hospital, is an important part of your costs. I just wonder, though, to keep current and keep your technology modern, won't you also have to spend some money improving facilities you are talking about using? I can't believe that you are going to keep the academic medicine technology flowing in the interrelationship between your training facilities and your training hospital if you don't, in fact, upgrade their capital equipment, upgrade their equipment in a way that relates to the medical school.

I would agree you are going to save some money by utilizing Walter Reed and Bethesda, that you are talking about.

Dr. WILBUR. Yes, sir; in capital and also in yearly deficit. A university hospital is a very expensive operation, as I found out in previous jobs I have had. We are assuming that whatever the expense of the hospital currently is, you know, of Bethesda and Walter Reed, that we would not significantly add to this expense over and above the \$21.5 million which you put as a deficit.

Senator SCHWEIKER. You are talking about the money in the regular operating budget?

Dr. WILBUR. Yes, sir.

Senator SCHWEIKER. You are not putting it in your figures?

Dr. WILBUR. No, sir; it is over and above the current operating budget which is why it seems smaller than it otherwise would.

Senator SCHWEIKER. That is all I have to ask.

Senator BENTSEN. Dr. Wilbur, it has been emphasized this is an authorization for the construction of this university and not a requirement. How firmly committed is the Department to its construction, if you can give the committee a feel for that?

Dr. WILBUR. We are firmly committed to the university concept covered by the bill. In fact, Secretary Laird restated our support of this concept in a letter he sent to Chairman Stennis yesterday. On the other hand, I believe you are quite right in characterizing the bill as merely authorizing legislation. As I understand our military construction program, it would not be possible for us, assuming that this bill is enacted in substantially its present form, to establish the school unless subsequent legislation were enacted actually appropriating the funds which this bill would authorize. In other words, we cannot commit ourselves to any specific major construction project such as this until all of the applicable requirements built into the Federal system have been met.

Senator BENTSEN. Dr. Wilbur, unless you have further comments, we are very appreciative of the attendance of you gentlemen. Thank you very much.

Dr. WILBUR. Thank you very much.

Senator BENTSEN. Our next witness will be Dr. Milton Davis who is president of the National Medical Veterans Society.

Dr. Davis, we are pleased to have you and look forward to your testimony.

STATEMENT OF DR. MILTON V. DAVIS, PRESIDENT, NATIONAL MEDICAL VETERANS SOCIETY

Dr. DAVIS. Thank you, Mr. Chairman.

I am Mr. Milton Davis, of Dallas, Tex., engaged in the private practice of medicine and representing here the National Medical Veterans Society.

We are very pleased to be afforded the opportunity to present our testimony. We have provided your staff with a 10- or 11-page document and we would respectfully request that that be entered, if appropriate, into the record of the proceedings, and I would like to excerpt that.

Senator BENTSEN. Without objection it will be done.

Dr. DAVIS. The basic problem is a low retention rate of career military medical officers. The service is not attractive enough to doctors at the present time.

Our organization supports the recommendation in H.R. 2 presently called the Revitalization Act of the scholarship program. We support the provisions lifting restrictions on promotion and numbers of flag-rank physicians. We oppose the creation of a military medical school simply because in our viewpoint it won't do the job.

The Defense Department did draft doctors and, therefore, the service doesn't have to be attractive. In order for them to want to stay, many changes have been made. Creation of a military medical college in and of itself will not accomplish these changes and could delay further needed reforms.

The need for graduating more physicians overall for the general public is already being met. A Government military medical college will compete for faculty and staff with existing private and public medical schools where personnel is already in short supply and competes for Government money needed elsewhere. The service characteristics, which are not conducive to making the military a career as a doctor, used to be thought to be difficult to enumerate. However, there have been many surveys conducted by the individual services, conducted by the Defense Department, some conducted by us, and some conducted by the American Medical Association.

Without representing that we would provide you with statistics or any authoritative report on these, because they are public, and are obtainable, we give you our impressions.

The living quarters are not adequate for the young family. There are not enough schools for the children. There is a great instability in the location of assignments. There is inevitable separation from family by virtue of assignment overseas, sea duty, special assignments and so forth.

The relationships between junior medical officers and senior medical officers and between junior medical officers and senior line officers just doesn't quite stack up to the relationship between a young doctor who goes to a community where he is needed, where he immediately is—has, at least, available to him a position of prestige and status because he is filling a need in the community.

The professional responsibilities that are assigned to younger medical officers and to those without professional training in specialties in medicine are not conducive to retention.

There apparently have been many instances of underutilization of the medical officers' time in many assignment locations. Financial remuneration is certainly a factor but you will see, sir, we don't put that high on the list; that is No. 8 on the list. We certainly do not think it is unimportant but we certainly don't think it is the most important factor.

The limited opportunity for promotion and still continue the active clinical practice of medicine is a fact and this is why we support the relief of the restrictions on flag rank.

There are insufficient incentives in the military medical life to excel, to get along with peers and subordinates. There is plenty of incentive to get along with your superiors, to work harder and longer hours and to accomplish in public research work.

The military medical reserve is to us a very important matter relating to the national security.

Very few younger and lower ranking officers affiliate voluntarily with the reserve components because of the fear of financial ruin in the event of recall.

This could be turned around. If by statute reliable procedures could be adopted governing periods of time an officer might be retained in the event of recall and insuring a just rotation based upon prior service, time in the reserves and other factors.

We of the National Medical Veterans Society respectfully urge that you not create a Federal military medical school. Instead we recommend that immediate steps be taken to make the military medical career more attractive, to insure that physicians are ordered to active duty only when needed, to insure that all physicians on active duty are fully utilized and that none are idle, to expand the current scholarship program for medical students.

As a corollary or as corollaries, we recommend that we utilize the available capabilities for communication and transportation, which in the medical field we call evacuation, to bring the problems and the patients to the doctor. This would allow better utilization of medical manpower—the doctor and allied health personnel—and avoid assignment of people where the need is slight. By so doing, assignments could be more stable, tenure in a given location longer, facilities made more functional, more attractive and efficient.

The answer to the Reserve problem may lie in statutory assurances against possible inequities in recall and retention.

Mr. Chairman, Senator Schweiker, and other gentlemen, we appreciate very much the privilege of appearing here and of presenting this statement.

We would welcome any questions you might have about our position.

(Prepared statement of the National Medical Veterans Society follows:)

At the time of preparation of this statement it is our understanding that H.R. 2 has been passed by the House and forwarded to the Senate as Report 92-524 and that H.R. 2 and S. 853 are presently under consideration. This statement is prepared for submission to the Committee on Armed Services of the United States Senate, the Honorable John C. Stennis, Chairman, on behalf of the National Medical Veterans Society (Appendix 1). We appreciate the opportunity to submit this statement.

We do not favor creation and operation of a military medical college by the United States government because, in our opinion, it would not do the job in-

tended and may delay further necessary steps to improve military medical career incentives.

A. The most pressing need (set of needs) in the military medical service today is *reflected by* a low retention rate of career military and naval medical officers.

B. We have studied S. 853 and H.R. 2, and it is our considered opinion that passage of this legislation and creation of a military medical college will not correct the underlying problems, may aggravate some already existing problems and may even create some new ones.

C. The authority to draft doctors, granted to the President by the Congress since the early 1950's, has provided the Department of Defense with sufficient numbers of physicians and dentists to man the military medical departments. It has also enabled the Departments of the Army, Navy and Air Force to continue certain administrative, procedural and personnel practices which are objectionable to many in military medicine and which, in some instances, may have impeded progress which could lead to a higher quality medical service. Because they could fill their numerical needs with doctors subject to the draft, the Services have not been forced to face up to reality and alter their policies and procedures sufficiently to make military medical careers more attractive. This will likely hold true as long as doctors are subject to draft. The creation of a military medical college could divert enough attention away from some of the problems which exist to delay further their needed correction.

D. The Military and Naval Medical Reserve is dying.

GENERAL

1. Since 1946 the existing medical schools in this country have increased to approximately 100 and by 1975 will have doubled their enrollment and their number of graduates. Further, more and more medical schools are offering accelerated schedules leading to the M.D. degree in 3 years by doing away with the four month summer vacation. The need for more doctors is already being met.

2. Personnel for medical school faculties remain in rather short supply due to the increase in the number and size of medical schools plus the same social, cultural, professional and financial enticements in private practice that lure doctors away from military careers.

3. The creation of a military medical college run by the federal government would place the United States government in direct competition with the state governments and private institutions which now operate medical schools.

4. The special professional needs of military physicians which are different from civilian physicians lend themselves better to training at the postdoctoral level than at undergraduate medical levels.

COMPARISON OF PRIVATE MEDICAL AND MILITARY MEDICAL CAREERS

It may be somewhat helpful if we engage in a little exercise comparing the life of the military physician with his counterpart in civilian practice. Since the problems do vary just a bit depending on age and maturity, we shall arbitrarily divide them into two age groups, the first, thirty-nine years of age and younger, and the second, forty years of age and older.

Recognizing that objectivity is difficult to attain and submitting the following as a viewpoint or as a group of opinions, it is our belief that the findings are representative of a rather broad consensus. As we approach each problem, we should ask, "Will a Federal Military Medical College correct this?"

DOCTORS 39 YEARS OF AGE AND UNDER

Living quarters

In the military, living quarters for junior officers vary all the way from adequate to non-existent and rarely are what the young doctor's wife has been dreaming about. In civilian life, even though debts and mortgages are involved, the pressures from the wife and the family usually result in clean, well located, often new and attractive living quarters, at least they were usually planned or selected by the young doctor's wife, herself.

Schools for the children

In the military, these vary from adequate to non-existent. In civilian life the doctor and his young family will often be influenced greatly in their decision as

to where they wish to live and practice by the schools that are available to their children.

Stability in location

Military requirements do not allow for very much stability in the assignment of junior medical officers. Whether anything can be done about this remains debatable. The fact is, very little has been done about it. In civilian life the doctor and his family may move if they wish, or they may find an attractive community, settle and locate there, allow their roots to become fixed and remain a part of the community of their choice for as much as a lifetime.

Separation by virtue of assignments overseas, sea duty, special assignment, etc.

Such is inevitable in military life if the Defense Department and military commanders meet their obligations. Enforced separation of the doctor and his family does occur in certain aspects of civilian practice, however, is entered into more or less voluntarily when it does occur, and is really quite rare.

Relationship of junior medical officers to their seniors

In our opinion, this is not truly different in the military and in civilian or academic medical practice, but it appears so to the junior officer. The Army Captain or the Navy Senior Lieutenant is constantly reminded that even though he is a doctor, he is a junior officer. While the junior man in civilian or in academic life has exactly the same situation, it is not brought home to him so forcefully and may well appear different. If the civilian doctor settles where he is truly needed by virtue of a lack of medical personnel in an area, he is not junior, but occupies a senior position immediately. One may do exactly the same in the military by accident of assignment, although he is always under orders from senior people. As we have examined the available questionnaires and conducted our own on an informal basis, this seems to be one of the chief reasons for dissatisfaction of the younger medical officers.

Professional responsibilities

There is a rather close parallel between the professional responsibilities of junior military medical officers and professional responsibilities early in private or academic practice. The real difference here probably lies in the area of assignments. A doctor in civilian practice will accept professional responsibilities that are not his first choice for a variety of reasons, such as to defray the expenses of living or to become established in a community or in an area, etc., but not because he is simply assigned there by order of the C.O. On the other hand, so many of the younger military physicians, especially those who have the military occupation specialty designation of general medical officer (one who has had only an internship and no residency training) will be assigned to what really is in truth just triage duty or dispensary duty and often has very little to do. The doctor in civilian practice does triage work and runs a dispensary in his office, but then he follows his own patients to the hospital and treats them. It has come to our attention that to a limited extent a few military and naval installations have similar arrangements, however, this does not appear to be general policy and is a mechanism which, in our viewpoint, has long been overlooked by the military medical departments. To be sure, an officer in charge of a dispensary at an isolated base can not travel several hundred miles each day to make hospital rounds after he holds sick call, however, in peace time, such situations should be less common than they are in times of greater duress.

The military really needs to address itself to this particular problem as one means of making the military medical service more attractive to the younger officers, most of whom have little taste for dispensary duty. As a corollary, we have very little defense when a doctor either during his active duty or after having been separated tells us, "I was assigned at a base with five other medical officers. We spent about 5% of our time holding sick call for active duty people, about 10 or 15% of our time taking care of military dependents and a few retirees and the rest of the time we played cards, played golf, loafed, or just waited around. I don't see why they had to draft me for this." Such is not just an isolated instance. There apparently are still many people who enter military service to practice medicine and just don't have much to do. The ones who are better motivated soon tire of their lack of utilization.

Our Society along with many others has repeatedly urged an improvement in personnel practices and utilization of medical personnel by the military. This has been said so often by so many people in and out of positions of authority that it almost represents a platitude at this time. Even though the services have done

much to correct this already, it is not enough. In our opinion, the creation of one or five federal military medical colleges will not result in a larger career medical service unless we correct some of these other problems or find means to work around them, when they are basic to military needs and not really correctable.

Financial remuneration

This is the most tangible and perhaps the one aspect of these many problems which seems to get talked about the most, although it may truly not be the real reason why doctors leave the services. Without any question, it is important when a junior medical officer would expect to make twice as much or more as soon as he becomes established in civilian practice. On the other hand, there are still quite a large number of highly qualified young physicians who take positions with medical schools at a relatively low pay scale because of the opportunities for professional advancement. It is our opinion that the relatively low pay in the military is just one important factor leading to dissatisfaction and probably would not loom as significant if we could do something about the living quarters, the schools, the stability of assignments, the relationships of the junior to the senior officers, the professional responsibilities and advancement opportunities and, perhaps most important of all, if we could do something about the real or imagined waste of time in the military about which so many of our young doctors complain.

DOCTORS 40 YEARS OF AGE AND OVER

One of the more important accomplishments of the Congress in this field has been one of the major objectives of our Society and of many other interested groups. This was the act entitled Public Law 90-228 of the 90th Congress, signed into law on or about December 28, 1967. As we understand this act, the needs of the Army, Navy and Air Force, rather than specific tables of organization or other criteria, determine promotion of officers of the medical corps and the dental corps in grades below brigadier general and rear admiral. We approved of this act and have spoken in behalf of the principle involved on many occasions. However, it doesn't go quite far enough to do the job. Officers who are over 40 years of age very often find that promotions which they have earned would take them out of the practice of clinical medicine, therefore, are not desirable (Appendix 2). In our viewpoint, the services could retain many more seasoned medical officers if Public Law 90-228 should be amended to include flag rank.¹ Another viewpoint has been expressed to us privately by some of the staff people of the Congress and others suggesting that the Congress attempt to do away completely with the military rank structure for medical officers. Recognizing the complexity of such action, it may have considerable merit and may be one of the things that needs to be considered.

Also, the pay scales do need to be higher as well as alterations in the rank structure which would enable one to continue to rise up the ladder of promotion and not be arbitrarily removed from the responsibilities of clinical medicine by well earned promotions. The problems of living quarters, stability of assignment, separation from family and relationship to senior officers are basically just about the same for older as they are for the younger officers, although one would expect a more mature approach after 10 or 15 years of service than that exhibited by the youngsters fresh out of internship. In the opinion of our Society, the government incurs quite a significant professional and financial liability by losing the services of qualified people in their 40's and 50's and should take every reasonable step to make the service attractive enough for these mature officers to remain for the rest of their careers.

PREMEDICAL COURSES AND SCHOLARSHIPS

Our Society would like to express strong approval of the idea of strengthening the premedical courses in the Service Academies and broadening and extending the scholarship programs from the Department of Defense for medical students with resulting extended periods of obligatory service. However, these mechanisms will, in our opinion, fail just as the military medical college will

¹ Provided for under Report No. 92-524, House of Representatives, "Uniformed Services Health Professions Revitalization Act of 1971", which would amend Section 2, Title 10, United States Code by amending sections 3202(e) and 8202(e) by striking out "in grades below brigadier general" and insert in place thereof "in the various grades", and by amending Section 5793 by striking out "in grades below rear admiral" and inserting in place thereof "in the various grades".

fail to improve career attractiveness if we don't accomplish sufficient improvement in personnel practices and utilization of military medical people while they are on active duty to cause a complete turn around in their attitude towards service careers.

THE MILITARY MEDICAL RESERVE

It is the opinion of our Society that the virtual death of the military medical reserve is a threat to the national security. At the present time we have in the reserve a few high ranking officers and a few younger fellows who have periods of obligatory reserve time by virtue of having been inducted, enlisted or appointed prior to their 26th birthdays. Why are young medical officers unwilling to sign up for the reserve? The chief concern of the young physician is that he can not afford to remain in the reserve for fear of extended retention on active duty in the event that he is called back. The typical physician has such heavy insurance and other financial commitments that an extended period of time on active duty after he has begun to establish himself in practice would result in financial ruin. It is the opinion of our Society that the Congress needs to pass legislation which would insure the reservist against extended retention should he be recalled and which would set up a system of priorities similar to the point system used at the end of World War II to determine who should return home first, which would govern in an equitable manner which of the reservists are to be recalled first and, *by statute*, how long they may be retained. Since the 1950's the Selective Service laws passed by our Congress have resulted in rotation, in that no one has been held involuntarily on active duty longer than two years before being replaced by one of his fellows. It is our opinion that the same principle could be applied to reserve duty. If statutory restrictions were placed in effect insuring against unfair recall and extended periods of retention should one be recalled, there would be a complete about face resulting in willingness of young physicians to sign up voluntarily for the reserves, where our national security so desperately needs them.

Mr. Chairman and other members of the Committee, we of the National Medical Veterans Society respectfully urge that you not create a Federal Military Medical School. Instead, we recommend that immediate steps be taken to make the military medical career more attractive, to insure that physicians are ordered to active duty only when needed, that all physicians on active duty are fully utilized and that none is idle. To accomplish this we feel that the sophisticated, currently available military communications capability and the proven effectiveness of transportation (evacuation) by current procedures should be utilized to the utmost to bring the problems and the patients to the doctor, thereby better utilizing medical manpower (the doctor and allied health personnel) and avoiding assignment of people where the need is slight. Assignments could then be more stable, tenure in a given location longer and facilities made much more functional, attractive and efficient. Further, we favor increasing the number of scholarships from the Department of Defense and strengthening and extension of the premedical programs in the Service Academies. We not only need to get more doctors into the service voluntarily, we need them to want to *stay*. Likewise, we need statutory assurances against possible inequities in recall and retention so that an increasing number of prospective younger reservists will sign up voluntarily, then we need to utilize them in their professional capacities both on active and reserve duty, or else the better motivated ones will not remain.

APPENDIX 1

The National Medical Veterans Society is a voluntary organization of physicians who have been on active duty in the Military Service. It is one Veterans' organization which has never sought any "Veterans' benefits" for its members. The Society existed as individual local groups in metropolitan areas from 1946 to 1951, when circumstances stimulated us to form a national society. We have met semiannually with the American Medical Association since then and have been relatively successful in keeping Councils and Committees of that association informed of our viewpoint about military medical matters. We have maintained a continuing interest in national legislation pertaining to military medical matters, Veterans' medical care and the draft and have submitted statements or testified at hearings numerous times before the U.S. Senate and the U.S. House of Representatives Committees on Armed Services.

APPENDIX 2

An example might be as follows, a man graduates in medicine at the age of 26, finishes his internship at the age of 27 and finishes a four year residency at the age of 31. He will go on active duty or will soon be promoted to the rank of lieutenant commander or major. Should he choose to remain in the military for a career, he then can only have one or two promotions and still practice the specialty to which he has devoted a lifetime of study and training. Should he be promoted to the rank of brigadier general or rear admiral, very few positions exist where he could continue to practice. This is an instance of legislative and administrative deprivation of the services of the special talents of a highly qualified individual.

Senator BENTSEN. Dr. Davis, you made some very salient points and very concisely so. You have stated in particular some of the negative factors that hurt in the retention of doctors in the service.

Would you care to amplify at all any more than you already have as to the incentives needed for retention of active men in the service and people in the Reserve?

Dr. DAVIS. Right.

Senator BENTSEN. We seem to have a hiatus here for those who are in for a very short period in the Reserve and then those who are reaching the culmination of their retirement period in the Reserve and here is the gap in between.

How do we really get at that to try to have the reservists of that age group?

Dr. DAVIS. I think one of the things that is most glaring, representing the military environment, is really basically germane to the military system as we know it, and that is that ratings, by and large, at all levels, are performed by one's superiors.

Now this is really not true in your case. You are rated by your constituents.

Senator BENTSEN. They are my superiors.

Dr. DAVIS. Sure; sure; and I am rated by my patients as a doctor in private practice. I am also rated by the nurses I work with and by other physicians and by technical people who are so necessary for everything that I do in the conduct of my work.

We would like to see a sort of a computerized rating system which would rate a military medical officer throughout his entire career. We could even go further. For example, as an incentive, I think you are going to have a lot of problems when you try to pay the doctor more. We think you need to—we recognize it is very difficult but you might maybe pay them more in retirement based on a 20-year-or-more history of facts. For example, we have already made some difference in pay; for example, the Congress many years ago authorized hazardous duty pay, submarine pay, flight pay, matters of that kind. We already have a differential under the law which really makes it a different ball of wax for a reservist who happens to be on active duty for 20 years and a Regular who happens to be on active duty.

I am not as certain of this as I would like to be, but I have been informed that, for example, a man who is a Regular Army medical officer and spends 20 years leading to retirement, were he thereupon to take a Government job as, for example, a civilian employee in a medical installation, he would be limited in what he could draw in total pay from the Government. Whereas, if he had been on active duty in the Reserves for 20 years he could draw his retirement pay as a

reservist and also get the full pay which really prevents, in essence, the employment of people who have been in a career, a lifetime career in a civilian capacity.

Senator BENTSEN. Dr. Davis, will you excuse me, I have another commitment and the chairman has returned.

Dr. DAVIS. Mr. Chairman, I am Dr. Milton Davis from Dallas, Tex.

Senator BYRD (presiding). Glad to have you. Senator Schweiker, do you have any questions of Dr. Davis?

Senator SCHWEIKER. Yes, Mr. Chairman.

I feel, Dr. Davis, you made a very constructive, positive statement. I just wondered, did you have access to this GAO report I cited earlier?

Dr. DAVIS. Yes, sir.

Senator SCHWEIKER. So some of your statement was based on your knowledge of what the General Accounting Office found out about the general utilization of medical personnel?

Dr. DAVIS. As a matter of fact, I find myself almost in full agreement with the point of view expressed in that document except where they are vague. This document is very specific in a few areas. For example, I work regularly with nonphysicians who are hospital commanders. They are civilians; they are not military. I think this is a very good idea. Now I don't really like to work with a bad hospital administrator but we are not talking about bad ones; we are talking about good ones. And to me the operation of a hospital in the civilian sector or in the military sector is very, very big business, just very large payroll, matters such as procurement, accounting, supply, pension programs, insurance programs, all things which are not medical; they are administrative; they represent business.

I even could foresee the day when the Congress in its wisdom might change the whole concept of military hospitals. For example, at the present time let's say you take a training base in Texas which is commanded by, say, a colonel and in moves a division which is commanded by a major general. There are no problems. The colonel knows his work and the general knows his work.

In the military hospital we seem to be married to a concept that the highest ranking officer has to be the commander. I really think we are ready to get away from that. I think we ought to separate the professional aspect of patient care and research from the business aspect of running a hospital. We do this very, very comfortably in civilian life, of course, with the normal argument and backbiting and all that; but you know we are just people; everybody has that.

We don't really need to have the highest ranking individual on the post be the hospital commander. We could have a very well-trained chap who has got maybe a master's degree in hospital administration and maybe a 15-year record in the service of knowing where the officers' head is, and he can run the hospital and he doesn't have to be the highest ranking man; and then we can have the chief of surgery or chief of professional services be a colonel or Navy captain or whatever is appropriate.

I really think we need to come to a change in concept there and I find myself in virtually complete agreement in that regard with the recommendations of the General Accounting Office statement.

Senator SCHWEIKER. You also say very significantly we don't need to get more doctors in the service voluntarily; we need them to want to stay. I gather from that conclusion you feel that merely setting up a new school of medicine really isn't very directly related to the matter of whether they want to stay.

Dr. DAVIS. We don't think it will help at all, Senator. This is our whole point. The problem is retention. We haven't had really since 1940 any problem getting doctors in the service. As I am sure you are aware, in World War II they didn't draft any doctors; we were all in voluntarily. There was a draft but the doctors volunteered. They never needed to draft anybody.

We then came up with a doctor draft at the time of the Korean war and then in 1957 the Congress, in its wisdom, really did away with the actual law of the doctor draft and put in the basic Selective Service Act and that is where it is now.

We don't really think that the creation of a military medical college will have one iota of influence on the young mother hen who needs a nest, who is a 28-year-old mother of three who is a doctor's wife. She wants some roots. She wants to live somewhere longer than a year; she wants to know where her husband is going to be next year. We think these things may not be compatible with a very fluid operational combat situation, but we are hopeful, as I am sure you are, that our elected officials are going to keep us out of wars and that we are going to be talking about sort of a peacetime situation. I hope, for a long, long time, and I think we have got to gear some of our thinking to what we are going to do with these people when we are not fighting wars.

We don't really think the creation of a military medical college will do this job. It isn't that we oppose it; it is just that we don't think it will do the job and we would really like to see the money put elsewhere; and then we would like to see these things changed that will make the doctors want to stay in. It wouldn't take a whole lot of change.

Senator SCHWEIKER. And far less money, I gather?

Dr. DAVIS. Well, perhaps so. I think it is very costly for you to take a fellow, for example—General Jennings, I think, or General Crouch, referred a few moments ago to the retention rate of 1 percent of the 2-year boys, and 25 percent of those who have trained. Well, there is a lot of story there. Those of us who have served in the military as physicians either had a good assignment or a bad assignment, you know, and to a physician a good assignment is where he is with lots of patients and where his professional talents are needed, usually in a field of medicine that he is interested in.

You see, one cannot escape the fact that the practice of medicine today is hopelessly fragmented. We don't really recommend this. We don't even think it is good but it is, and a doctor now who graduates in medicine usually has a decision: "I want to be a family doctor," or "I want to be a radiologist," or "I want to be a urologist," or "I want to be a heart specialist," and in whatever he wants to be he wants to be that in the service.

Now, what you have done is when you provide these people with the opportunity to get a specialty training program while they serve on active duty, we call those residents—that is our official term for training in postgraduate training in medicine—and let's say that I

want to be a cardiologist and that I get a job as a resident in cardiology at Walter Reed Hospital. Well, that is a good job. I am working in a good professional atmosphere; I have got senior people who are qualified, junior people who are qualified. It is what you want. OK; 25 percent of those stay in but that is not even the whole story.

The whole system of assignment of medical officers in all the services is based on specialty qualifications. When I went into the military service after 1 year of internship I was assigned to a dispensary; and now I have another qualification. If I were to go back in now, I would get a better job so that they keep 25 percent of these people who have completed residencies probably more than anything because they assign them to a better duty, that is, better from their viewpoint, a more acceptable duty to them.

Now we really feel that we ought to cut down to the maximum on these duty stations which doctors don't like, not because doctors don't like them but simply because this is poor utilization of an expensive resource.

We don't see any reason in the world in peacetime to put a doctor on a small ship or to put a doctor in a dispensary out somewhere. We think we have the greatest communication and transportation system known to man in the military and we ought to bring the problems to the doctor and to bring the patient to the doctor and to let the doctor be quite a great deal more stable in his assignment, where his kids can go to school, where his wife can learn who her neighbors are and all the things that everybody wants.

Senator SCHWEIKER. That is all I have, Mr. Chairman.

Thank you very much.

Senator BYRD. Thank you, Senator Schweiker.

Thank you, Dr. Davis. That is very interesting testimony you have given the committee today.

Dr. DAVIS. It is a great privilege to be here, sir.

Senator BYRD. The next witness is Dr. Richard I. Feinbloom, Physicians for Social Responsibility, Boston, Mass.

STATEMENT OF RICHARD I. FEINBLOOM, M.D., CHAIRMAN, PHYSICIANS FOR SOCIAL RESPONSIBILITY; DIRECTOR, FAMILY HEALTH CARE PROGRAM, HARVARD MEDICAL SCHOOL AND CHILDREN'S HOSPITAL MEDICAL CENTER, BOSTON, MASS.

Dr. FEINBLOOM. Thank you, Mr. Chairman.

Senator BYRD. Welcome to the committee.

Dr. FEINBLOOM. I am Dr. Richard I. Feinbloom, and I am the chairman of the Physicians for Social Responsibility, and I direct the family health care program of the Harvard Medical School and Children's Hospital Medical Center in Boston, Mass.

The family health care program provides undergraduate and post-graduate training in family medicine.

Physicians for Social Responsibility is a national organization of doctors, many of whom are also medical educators who are interested in the interphase between medicine and the military.

One of our organization's first public actions some 10 years ago was an appearance before a congressional committee holding hearings on the proposed fallout shelter program. We presented research later

published in a book, "The Fallen Sky," on a hypothetical thermonuclear attack on Boston and Massachusetts, demonstrating that a rational medical response to the resulting disaster even with fallout shelters would be impossible. This testimony played a part in persuading the Congress not to undertake a large-scale, costly civilian defense program.

On behalf of Physicians for Social Responsibility, I want to express my opposition to H.R. 2. I do not feel that a Uniformed Services University of the Health Sciences should be established. There are four reasons for my opposition:

(1) The goals of military training and medical education are so fundamentally different that the Military Establishment ought not to be responsible for teaching young people how to be physicians.

(2) The establishment of a military medical school would be a precedent for military involvement in other areas of education.

(3) The costs of the proposed school are very high.

(4) The medical manpower crisis predicted for the military may be less serious than suggested.

Let me elaborate: First, there is a basic conflict between the military and medicine which argues for keeping a clear separation between the military and the primary undergraduate professionalization of physicians.

There are irreconcilable contradictions in the objectives of medicine and the military. They are at opposite poles. An example is the use of chemical and biological weapons. Physicians, dedicated to life, must find objectionable the indiscriminate destructive effects of these weapons which have been described as "public health in reverse."

The military subordinates and twists medical knowledge to its combat objectives. Whenever there is a choice, medicine takes second place to military considerations. How can this same military impart to young students of medicine a reverence for life and medical ethics during the formative stages of their medical careers?

There are specific passages and widely respected medical oaths which appear to contravene physician participation in the development or use of such weapons which use biological knowledge to kill and cause disease. For example, the Hippocratic oath states:

I will use treatment to help the sick according to my ability and judgment, but never with the view to injury or wrong doing. Neither will I suggest such a course.

The oath of Geneva, a modernization of the Hippocratic oath, formulated by the World Medical Association in 1948, states:

I will not permit considerations of religion, nationality, race, party, politics or social standing to intervene between my duty and my patient; . . . even under threat I will not use my medical knowledge contrary to the laws of humanity.

Even more specifically, the Code of Ethics in Wartime of the World Medical Association states:

It is deemed unethical for doctors to weaken the physical and mental strength of the human being without therapeutic justification and to employ scientific knowledge to impair health or destroy life.

How can the military in a setting of undergraduate medical education reconcile its actions in the field and in secret biological laboratories with the elements of medical ethics embodied in these oaths?

There are many examples of conflicts of interest and of marriages which are probably best not made. Supreme Court judges are not permitted to hold stock in companies lest their impartiality be compromised by their financial interests. Such a conflict of interest exists in the concept of a military sponsored medical school.

We need an independent medical education which can be a critic of military actions in the field when they conflict with medical ethics. It is ultimately to the military's advantage to have these restraints. The doctor has an overriding responsibility to the care of his patients, and a particular interest in strengthening and observing those parts of international law which seek to protect civilians, maintain the neutrality of the medical services themselves, and to outlaw weapons of indiscriminate destruction. Physicians for Social Responsibility is attempting to have this concern and commitment taught as a regular part of the undergraduate medical curriculum. Today's students have increasing interest in these issues.

These considerations are of only secondary interest to the military. For example, in Indochina, medicine has been used to "win the hearts and minds" of the peasants in the pacification programs by Special Forces aidmen who were combat troops and the hard-won noncombatant status and neutrality of the medical services has been compromised. This program was particularly disturbing to physicians.

Now it is understandable that the military will subordinate these medical ethics considerations but this is precisely the reason why they should abstain from undergraduate medical education. The very badly needed leavening influence of an independent medical critique of certain military practices in the field would be damped by the military establishment of its own medical school and would serve to isolate and insulate the military from what civilian medical influence remains on these practices.

In the spring of 1971, Physicians for Social Responsibility sent a mail questionnaire to all returned physicians who had been assigned to the U.S. Army command in South Vietnam between 1966 and 1970, to inquire about their experiences and attitudes. One question asked was, "Based on your experience do you think that there is a need for a redefinition of how medicine should be used in the military?"

Sixty-five percent of the 304 physicians who completed the questionnaire replied to this question by checking the answers which stated, "Change in present use needed, that is, set limits." This answer expressed a perceived conflict between the values of these doctors and their assigned military roles. If this expression of dissatisfaction is important, it is difficult to imagine graduates of a military medical school having such a critical frame of mind.

Now I am not saying that there is no need for career medical officers. What I am saying is that these career medical officers need unbiased exposure to their medical traditions during their formative years. We must not let the intrinsic conflict between medicine and the military in which medicine must, of necessity, take second place on the battlefield compromise the fledgling student's access to a full and complete understanding of what it means to be a physician.

Point 2: The logic of the argument for a military medical school would also dictate the military's involvement in other aspects of higher and perhaps lower education. If we have a military medical school,

why should we not also have a military law school, a military theology school et cetera? The same arguments of greater efficiency and higher retention of personnel which are advanced in support of H.R. 2 would justify a military penetration of all levels of education.

Is this a precedent we want and the direction in which we want our society to move? If efficiency demands this price, then I am in favor of less efficiency. The military plays a vital role in the defense of the United States. Its prestige and respect in the country is not at its highest. But the prescription for the military's problem should not include the incorporation of traditional civilian areas of activity like undergraduate medical education under an increasingly isolated and autonomous military umbrella. We must preserve and encourage civilian medical influence over military practices with medical implications. When doubt about emphasis exists, we should not be afraid to err on the side of civilian control.

Point 3: Civilian medical education is in precarious financial difficulty at the present time and the expenditures for this new school look big by comparison. To quote the analysis of Dr. Richard Magraw in his editorial which appeared in the *New England Journal of Medicine*, December 9, 1971:

The anticipated expenditures for one Health Sciences University of \$100 million in startup costs over a 10-year period, leading to an annual federal appropriation of \$20 to \$30 million for operating costs, exclusive of clinical facilities, would appear to be a serious drain on scarce federal funds. In comparison, total direct institutional support for all the 108 existing United States medical schools under the Health Professions Educational Assistance Program during 1971 was \$97.3 million, including \$20.3 million in loans and scholarships, but excluding \$75 million construction for teaching and related facilities.

Furthermore, the expectation is that even more spending is round the corner. The final paragraph, on page 21 of the report to accompany H.R. 2, states:

Finally, there is another provision in the bill which recognizes that if the concept of the University of Health Sciences proves as effective in operation as envisioned by the Committee on Armed Services, similar universities would be desirable in other geographical areas of the United States which offer the same medical resources as are available in the Washington area. Thus the provision requires the Secretary of Defense to report to the Congress no later than June 30, 1976, on the feasibility of establishing similar universities in whatever location he deems appropriate.

When the professors at this proposed school compete for research funds, the backbone of academic excellence, will the review committees be able to maintain their impartiality? Conversely, will the Department of Defense reward these researchers on criteria other than academic excellence?

My last point: It is by no means clear to me that the physician manpower crisis discussed in the report to accompany H.R. 2 is as dire as it has been made to appear. As one example of a conflicting analysis of the military medical manpower situation, I quote in its entirety an article which appeared in *Medical News*, the newsletter of the American Medical Association, on December 20, 1971:

Reduction of up to 40 percent of the number of military physicians was directed by Richard S. Wilbur, M.D., Assistant Secretary of Defense—Health and Environment. Dr. Wilbur called for substantial reduction by the end of 1972, with the goal of cutting the number of military M.D.'s to 10,000 from the present level of 14,600. He expressed the belief that the military services had

more physicians than needed and that the needs can be met by increasing the efficiency of the medical corps.

Noting that nonmilitary physicians work about 56 hours, he suggested that military M.D.'s be given incentives, including more pay, and promotion opportunities to increase their patient loads. He also suggested a reduction in the number of M.D.'s in administrative posts. The manpower cuts would be necessary to achieve an all-volunteer force when the doctor draft ends in mid-1973, Dr. Wilbur pointed out.

His plan would include sharp curtailment of medical care provided to dependents and retirees by military M.D.'s. In many cases, such care would be provided in civilian facilities under an expanded Civilian Health and Medical Program of the Uniformed Services Program.

This statement suggests to me that there may be ways to reduce the need for military physicians and that another look at the sense of impending manpower crisis may be in order.

For all of these reasons, Mr. Chairman, I encourage this committee and the Senate not to establish a military medical school. Thank you.

Senator BYRD. Thank you, Dr. Feinbloom.

Your statement is certainly a constructive one. It presents a viewpoint that the committee has not had before. I am not necessarily in agreement with certain aspects of it but I think you make some significant points, particularly in regard to the financial aspect. You quoted the editorial from the New England Medical Journal, is it?

Dr. FEINBLOOM. Yes, sir.

Senator BYRD. I note from that the total direct institutional support for all the 108 existing U.S. medical schools under the health professions educational assistance program during 1971 was \$97.3 million, including \$20.3 million in loans and scholarships but excluding \$75 million construction for teaching and related facilities. Do I understand that to mean that is the total Federal contribution to all of these 108 medical schools?

Dr. FEINBLOOM. I think in terms of training and education. That would not include the research contributions that the Federal Government is making. In other words, it is an attempt by Dr. Magraw, who really is much more knowledgeable in this area than I am, to try to isolate those aspects which would allow a comparison to be made between the expenditures for the military medical school—

Senator BYRD. I think it is important that a comparison be made and this is a very interesting comparison.

I think the quotation on page 8 of your statement, in which you quote Dr. Wilbur as calling for a reduction of up to 40 percent in the number of military physicians, I think that is a significant statement. I planned to query Dr. Wilbur in regard to this question but I had to leave the meeting for a short time and was not able to do so. I think that is a very important point you raise and I want to, at the appropriate time, query Dr. Wilbur in that regard.

Dr. Feinbloom, do you have an opinion on the scholarship program?

Dr. FEINBLOOM. I have looked at that part of the proposal and I think that that, at least from my point of view, would be acceptable—that aspect of the bill.

Senator BYRD. Your opposition is only to the establishment of a medical school?

Dr. FEINBLOOM. That is correct, sir.

Senator BYRD. Thank you very much.

Dr. FEINBLOOM. Thank you.

Senator BYRD. The next witness is Mr. Frank K. Jones, Committee for Ethical Insurance, Berwyn, Pa.

STATEMENT OF FRANK K. JONES, PRESIDENT, CITIZENS COMMITTEE FOR ETHICAL INSURANCE, BERWYN, PA.

Mr. JONES. Good morning, Senator.

Senator BYRD. Good morning, Mr. Jones.

Mr. JONES. I am Frank K. Jones, president of the Citizens Committee for Ethical Insurance, of 560 Woodside Road, Berwyn, Pa. This is an incorporated organization, nonprofit, nonpartisan, primarily interested in insurance in all its branches and exerting efforts to eliminate or control hazards which insurance policies underwrite so as to obtain a usable insurance coverage at a premium which is reasonable and fair.

We examine each matter which comes to our attention to determine to what extent it relates to our objectives. The matter of health services is of paramount interest to every form of insurance.

When the formation of a medical services university to supply medical officers for the armed services came to our attention, we were impressed. We do not wish to enter into the details of the formation and operation of the academy but we do wish to make certain comments with the thought that they can be used in direction of the broadening of the program for the maximum good of the country.

(1) We endorse the proposal with the hope it will be expanded to eventually supply all properly trained personnel the armed services require.

(2) We endorse the proposal because it should eliminate or limit the need to draw on the already insufficient civilian medical force and thus improve the civilian services with possible reduction of costs.

(3) We recommend that at intervals of not more than 5 years additional universities will be established in each of the four time zones of the United States, in areas such as Appalachia to induce economic improvement in those areas and work toward population dispersal.

(4) We recommend that the Academies be opened to both male and female applicants and that subsidiary facilities be established to train secondary medical and nursing forces, with full cooperation to all federally operated and civilian operated training centers as already mentioned in testimony before the House Armed Services Committee.

Aside from the purely military application, we also wish to present our broad thinking of the possibilities of this new branch of the armed services.

(a) We believe this project is potentially valuable in improving the image of the U.S. Government and the U.S. Armed Forces worldwide by the expansion of the activities. We recommend that, under the supervision and direction of the Secretary of State, the Secretary of Defense, and the Secretary of Health, Education, and Welfare, provision be made for instant deployment at times of epidemic, earthquake, tidal wave, or other catastrophe.

(b) So far as the graduates who would be assigned to Navy activities, we believe that they might receive extension experience on a fleet of medical ships such as the privately operated ship *Hope*. This would

thus provide a ready naval unit in times of conflict and a valuable good will emergency fleet in times of peace.

(c) Those graduates assigned to Army and Air Force activities could be used similarly but with special emphasis to assignment on the domestic front in areas of national or local emergencies, in connection with the American Red Cross and the Salvation Army.

(d) Nationally, our study indicates that one of the things most needed is to take the pressure, and confusion, and uncertainty, and anxiety from the shoulders of those persons who have attained the age of 65, whether they have had previous military service or not. Presently it seems that this age group is receiving the least consideration.

(e) It is our belief that while the product of these academies will not be available for some years, that they be considered for future use in what we consider inevitable Federal involvement in total medical attention to its citizens, especially the elderly, even to the extent of what may be considered total socialized medicine. Private insurance is paving the way directly to that point by pricing fundamental health services out of reach of those who most need it and developing it into fringe-benefit service for those who can best afford to pay for it, the cost being passed on to the consumer, and that in itself is socialization, because it is not paid for by the beneficiary directly.

(f) We believe that such services should be at a price readily acceptable to the least affluent of our people between the ages of 65 and 70 and that after 70 the services should be entirely free.

Our master plan in this regard provides for the financing of the after-70 service without imposition of taxes. Later on we will release our complete plan.

(g) We recommend that special consideration be used, and this is repetitive, to placing the additional installations in localities such as Appalachia where they would be helpful in solving the economic problems of those sections by the attendant commercial activities generated, and, incidentally, might involve many worthy citizens in an opportunity to get into medical activities which might not otherwise fall to their lot.

I thank you, sir.

Senator BYRD. Thank you, Mr. Jones.

Those are all of the witnesses scheduled.

I might say this bill is more far reaching than the chairman of this subcommittee had expected when these hearings began. I think a lot more facts are needed and undoubtedly there need to be additional meetings of this subcommittee.

At this time I would like to mention organizations which indicated that they would submit statements on H.R. 2 for the record, rather than appear personally as witnesses. These are: (1) Dr. James R. Kimmey, American Public Health Association, Washington, D.C.; (2) Dr. John A. D. Cooper, Association of American Medical Colleges, Washington, D.C.; (3) Dr. LeRoy N. Larson, American Dental Association, Washington, D.C.; (4) Dr. Frank W. McKee, dean, School of Medicine, West Virginia University, Morgantown, W. Va.; (5) Dr. Charles W. Bliven, Federation of Associations of Schools of the Health Professions; (6) Dr. John J. Salley, American Association of Dental Schools, Chicago, Ill.; and (7) American Optometric Association, Washington, D.C.

(In addition to the above, the following statements were subsequently submitted:)

American Medical Association (Dr. Ernest B. Howard, executive vice president); American Nurses Association (Miss Eileen M. Jacobi, R.N., executive director); American Veterinary Medical Association); Prince George's County Council (Md.) (Kenneth V. Duncan, administrative officer); Reserve Officers Association (Col. John T. Carlton, executive director); Dr. Martin J. Raff, University of Louisville, Ky., School of Medicine.

Senator BYRD. The committee certainly appreciates the interest of these organizations in H.R. 2 and will be happy to give full consideration to their statements.

(The statements follow:)

STATEMENT OF AMERICAN ASSOCIATION OF DENTAL SCHOOLS

(Dr. John J. Salley, President)

CHICAGO, ILL.

Mr. Chairman, the American Association of Dental Schools has been on record since 1953 in opposition to establishment of a Federal military school for the health professions. We appreciate this opportunity to express our criticism of H.R. 2 which would establish a Uniformed Services University of the Health Sciences.

The Association adopted resolutions in 1953, 1957, 1961 and 1969 in opposition to legislation that would authorize military and other Federal agencies to award degrees in dentistry and the allied health professions. The position adopted in 1953 and restated subsequently is essentially the same as the American Association of Dental School takes with respect to H.R. 2.

In 1969, the Association's Executive Council reviewed the 1957 and 1961 policy of the Association in the light of the proposals embodied in the bill then proposed by Congressman Hébert and the alternative proposal developed by the Deputy Assistant Secretary of Defense. The Executive Council noted that Association's policy, as well as policy of the American Dental Association, expressed opposition to establishing degree-granting institutions in dentistry sponsored by an agency of the Federal government.

The following points summarize the position of the American Association of Dental Schools with respect to H.R. 2:

1. The Association recommends that proposals to establish an academy or university of the medical or health sciences, sponsored by a Federal agency, must not jeopardize the level of support now available to dental education through the Department of Health, Education and Welfare.

2. The Association recommends that other solutions to the health manpower shortage of the Department of Defense be investigated and, among these, the idea of providing an incentive program to existing dental schools, and schools of other health professions, be assigned a high priority of interest. For example, consideration should be given to the possibility of establishing, on a contract basis, an agreement between the Department of Defense and certain dental schools to accept a fixed number of undergraduate and graduate students annually who would then be committed to a period of military duty upon completion of their studies.

3. The Association recommends that feasibility and cost studies be undertaken and completed prior to final action by the 92nd Congress on H.R. 2.

4. The Association urges continued and increased support in the funding of postdoctoral certification programs currently conducted by the military and Federal dental services and that consideration also be given to the concept of establishing an academic postgraduate (or postdoctoral) institute of dental sciences, within the Department of Defense, to consolidate the various postprofessional educational programs in dentistry and in the allied health professions' education.

5. The Association reaffirms its long-standing policy that dental education should be conducted in a university environment which can provide adequate teaching resources in the basic and clinical sciences, experienced administrators, and financial support commensurate with its responsibility to provide the highest quality of health professions' education.

6. The Association believes that the Federal government should concentrate its energies and address itself to the entire national health manpower problem rather than to a problem of a single department and urges that the activities of the Departments of Health, Education and Welfare and Defense be more effectively coordinated.

7. The Association, in company with other similar organizations of schools of the health professions, views with concern the eligibility of the proposed academy or university by a regional accrediting agency member of the National Commission on Accrediting.

8. The Association is opposed to the establishment of a dental school sponsored by an agency of the Federal government which is given authority to grant the degrees of Doctor of Dental Surgery or Doctor of Dental Medicine.

The Association recommends that adequate time be taken for a thorough study of the situation. The House-passed bill is controversial within the health education community is evidenced by the strenuous opposition to the measure by the Association of American Medical Colleges, the American Dental Association, the Federation of Associations of Schools of the Allied Health Professions, and the American Medical Association, to name a few of the leading health professions groups which have spoken out against the proposal.

The Association is acutely aware of the needs of the Armed Forces for dental manpower. We realize that steps must be taken to improve the recruitment of dentists into the Armed Forces, particularly to follow careers. Once the selective service laws expire, as it appears they will, the doctor draft no longer will be available as an inducement to supply an adequate number of physicians, dentists and allied health professionals for the military.

But the American Association of Dental Schools believes that a Federal education system is not the answer. A better answer lies in more intelligent use of the present system of health professions education. Better incentives must be offered by the Department of Defense if an adequate supply of dentists is to be recruited by the Armed Forces.

This Association does endorse in Chapter 105 of H.R. 2, the Armed Forces Health Professions Scholarship Program. This chapter would provide professional scholarships for students of medicine, dentistry, or other health professions in existing accredited colleges or universities. As written in H.R. 2, the program would be severely self-limiting, however, as regards the eligibility of schools and students. In order to show his "sincere motivation and dedication to a career in the uniformed services," the student would be required to participate in military training while he is in the program.

Requiring a student of the health professions to take the time for military training would not only force an added burden for an already busy individual, but the new requirement itself is of doubtful value. The very fact of applying for the scholarship program should suffice to demonstrate the student's motivation as regards the military. Further, H.R. 2 would prohibit students receiving such scholarships from studying at institutions which as a matter of policy bar recruiting personnel of any of the Armed Forces from the premises or if the institution has "directed the disestablishment of Reserve Officers Training Corps units" at the institution.

If the Armed Forces want to secure the career services of top-flight physicians, dentists and allied health professionals, it seems clear to the American Association of Dental Schools that the most efficient and the most economical means lies in use of the excellent educational system already in existence. For this reason, the Association would prefer the Senate bill S. 1317 by Chairman Stennis and Mrs. Smith to the controversial provisions of H.R. 2, the House bill.

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

DECEMBER 7, 1971.

HON. JOHN C. STENNIS,
Chairman, Committee on Armed Services,
Senate Office Building, Washington, D.C.

DEAR SENATOR STENNIS: The American Dental Association welcomes this opportunity to submit the following brief comments on H.R. 2, the Uniformed Services Health Professions Revitalizations Act of 1971, as passed by the House of Representatives. The continuing problem of meeting the requirements for health professionals in the armed services is of great concern to the Association

With respect to dentistry, there currently are some 6,000 dentists on active duty in the three uniformed services. This is nearly 7 per cent of the nation's total supply of chairside dental practitioners. In order to maintain that level, the Corps have required in recent years an annual input of new dentists ranging in number from 1,400 to 2,200. That represents between 35 and 60 per cent of the 3,750 young men graduating annually from the country's 53 dental schools.

While all such entrants are technically volunteers, a more realistic view was voiced by the President's Commission on an All-Volunteer Armed Forces when, in discussing medical and dental entrants, it noted: "All but a handful enter because of the threat of being drafted. If the draft is to be eliminated, drastic action will be required to insure the continuation of health care now provided by the military medical system." The truth of this statement was underscored this year when the number of "volunteers" from the 1971 dental graduating class fell far below the required number and the quota was not finally met until after a call under the "doctor draft law" actually had been issued.

Parallel to the difficulty in attracting new dental graduates is the problem of maintaining an adequate cadre of career dental officers. All three dental corps are having grave difficulties in achieving a desirable mix of two-year and career officers. Not only are fewer and fewer of the two-year men willing to accept regular appointments, but more and more career dental officers, with years of fine service, are either resigning or requesting early retirements.

There undoubtedly is no single, simple solution to this set of problems. A number of actions will need to be taken—particularly if the all-volunteer armed services becomes a reality—to create a climate such that a sufficient number of dentists will consider career military service to be a desirable professional option. Some remedial action can and should be taken now. One such step is implementation of continuation pay and special promotion opportunities for dentists. Enactment of the scholarship program in Chapter 105 of the bill would be of immediate and continuing benefit. Administrative improvements, particularly in the Air Force and Army, directed toward making the dental officer a more equal partner on the health care team would be extremely helpful. And then increased professional opportunities for continuing education and participation in academic programs would be a further step in creating the necessary level of incentives for young dentists who might consider a military career.

H.R. 2, of course, is addressed partially to help realize this last goal. The provisions in the bill for affiliation agreements with existing academic institutions and for authorizing increased utilization of the excellent federal clinical research and related facilities that already exist are wholly commendable and should be adopted. With respect to dentistry, this would include such outstanding programs as those carried out by the National Institute of Dental Research, the oral research section of the Armed Forces Institute of Pathology, the dental research section at Walter Reed Hospital, the Naval Dental School that is part of the Bethesda Naval Medical Center and the Veterans' Administration activities in dental care and research. With existing national shortages in all categories of health personnel (estimated at 20,000 dentists by the Carnegie Commission and the HEW Commission on Health Manpower) all available resources such as these could be creatively used to assist in alleviating this problem, particularly in the area of advanced education programs.

A main thrust of H.R. 2, of course, is the establishment of a free-standing Uniformed Services University of the Health Sciences which would begin graduating medical students within ten years. The American Dental Association is bound by a policy position first adopted more than 18 years ago which is not in accord with this proposal. Since this provision of H.R. 2 is directed specifically at medical students, the Association policy is not directly applicable but it is not possible for the Association to support, at this time, the principle involved in this section. The Association appreciates the fact that it is recognized in the title and elsewhere in the bill that any program of this type should be broad enough to cover all disciplines and spectrums of the health sciences in order to provide health service that are truly comprehensive.

In summary, however, the Association wishes to reiterate its support of those aspects of the bill providing for cooperative agreements with accredited universities, and with federal agencies to support students and utilize facilities in both the federal and civilian sectors. The Association also supports scholarship programs for health professions students who are willing to make a commitment to serve in the armed services.

The Association also supports the amendment contained in H.R. 2 that gives new authority to the Secretary of Defense to promote medical and dental officers

to general and flag officer rank. In the existing situation, the Army and Navy each has statutory authority for an Assistant Surgeon General for Dental Services with the grade of Major General. The same authority has not been provided in the Air Force. This disparity is felt most keenly by Air Force members of this professional service who have been placed not only in inferior status in relation to their opposite numbers in the other branches of the Armed Forces, but also in relation to their own Air Force counterparts in the Chaplains Corps, the Judge Advocates' Office and the Medical Corps. If implemented the amendment could rectify an inequitable situation and improve the retention capability of the Corps.

Sincerely yours,

LEROY N. LARSON, D.D.S.,
Chairman, Council on Legislation.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

(Submitted by Dr. Ernest B. Howard)

Mr. Chairman and members of the committee, the American Medical Association appreciates this opportunity to present its views on H.R. 2, calling for the establishment of a Uniformed Services University of the Health Sciences.

At the very outset we cannot emphasize too strongly that our concern is that the men and women in our uniformed services should receive nothing less than the best in medical care. There is no reason why they should not continue to receive care from physicians trained in a medical education system which has proven itself to be unexcelled. The Association supports an expansion and greater utilization of this system rather than the development of a new and different kind of institution.

A substantial increase in the production of physicians in the United States is a major goal of the medical profession and others. The American Medical Association strongly advocates this increase in the production of physicians, and by supporting the establishment of new medical schools, expansion of existing schools, and changes in the medical school curriculum, seeks the accomplishment of this goal.

In the last ten years, the number of medical schools has increased from 85 to 108; and their total enrollment, from about 30,000 to over 40,000 with still further increases in prospect. This increase is the production of physicians has been made possible, in very large measures, by support from the Federal Government in the form of grants to the medical schools for construction and operation, and financial support of medical students through both loans and scholarships. On numerous occasions, the American Medical Association has supported such Federal programs, also urging that the Congress fully fund the programs. P.L. 92-157, recently enacted by the Congress, greatly expands federal support for medical education and will accordingly also greatly increase the numbers of physicians to be graduated from medical schools. In testimony on this measure, the Association advocated increased financial support to the schools and to students.

One aspect of the nation's goals for more physicians is the need of the uniformed services, and it is to this one aspect that H.R. 2 is directed. The American Medical Association believes it is vital that the number of physicians in the uniformed services be adequate to enable them to carry out their missions, and that those physicians be thoroughly trained and competent in order that those serving our country in the uniformed services might receive the best possible medical care. However, it is doubtful that these objectives can best be realized through establishment of a separate uniformed forces medical school, as called for in H.R. 2.

Physicians in the uniformed services need all the same skills as physicians in civil life. It may be desirable for physicians destined to serve in the armed forces to receive some instruction dealing specifically with conditions they will encounter in the service, but their basic training in medical matters should in no way be less complete or significantly different from that provided other medical students. A medical officer must first be a well-educated physician and his medical education should ideally be obtained in a regular medical school where the education of physicians is the primary objective.

In our opinion, it would be unwise to establish a separate medical school specifically to train physicians for the uniformed services in which all, or a sig-

nificant portion, of the physicians serving in these forces would receive their medical training. We believe it is important that the armed forces take full advantage of the resources and facilities of the existing medical schools of the United States in training their medical manpower, and that such training not be restricted in any degree to a single school established for that purpose. We also believe that it would be possible to train larger numbers of physicians in a shorter period of time, for a lesser cost if the existing schools are used.

There are various steps that the uniformed services can take to assure themselves of an adequate supply of physicians without establishing a separate Uniformed Services University. H.R. 2 provides that students in the proposed university shall be commissioned in "a reserve component of a uniformed service," and students who graduate shall be required to serve on active duty for not less than seven years. Such a program might be enacted in existing civilian medical schools and, in our opinion, would be effective in obtaining young physicians for the uniformed services. The purposes of the bill could be accomplished through increased support of scholarships for military personnel attending existing medical schools. We are pleased that the bill, as passed by the House of Representatives, now contains a program of scholarships and we strongly support this scholarship program.

H.R. 2 provides for the negotiation of affiliation agreements with an accredited university or universities in or near the District of Columbia," such agreements including "provisions for payments for educational services provided students participating in Department of Defense educational programs." There are three accredited medical schools in the District of Columbia and two others in nearly Baltimore. It would appear that affiliation agreements might be worked out with one or all of these schools without the need of establishing a new military school, possibly providing for expansion of enrollment of the present civilian schools beyond that now contemplated, in order to accommodate specifically students agreeing to serve in the uniformed services. This support could be in the form of scholarships or direct financial assistance to the medical school. Such agreements could be established promptly and would result in much earlier production of substantial numbers of physicians for the uniformed services than would be possible from a new and separate school. In the event, however, that legislative authority is required, this could be provided without the necessity of creating a formal Uniformed Services University.

H.R. 2 also proposes the utilization of existing federal medical installations in the District of Columbia, such as the Walter Reed Medical Center, the National Naval Medical Center and the Armed Forces Institute of Pathology. This seems entirely sound, and there is no reason why agreements could not be worked out with the existing D.C. medical schools, thus enabling them to increase their capacity for clinical training.

The American Medical Association fully understands and shares the desire of the Congress that the uniformed services of the United States have physicians that are adequate in number and second to none in their competence. It may well be that a significant step toward this objective would be the development of a program in which the Department of Defense would finance the education of a group of physicians who, in turn, would agree to serve in the uniformed services for a specified number of years, perhaps seven, as specified in H.R. 2. However, it is believed that such a program could be provided using the resources of civilian medical schools, rather than through the establishment of a separate Uniformed Services University of the Health Sciences.

The bill as passed by the House would remove existing statutory restraints on the promotion of medical and dental officers to flag and general officer rank. Thus, the bill provides an incentive to continued military service by giving appropriate military rank in recognition of professional capabilities and responsibilities. We support this provision.

SUMMARY

Our present expanding medical education system can be used to fulfill the needs of the armed services and thus assure its benefits to our servicemen and women without establishing a new "Uniformed Services University of the Health Sciences." We believe that the purpose sought to be accomplished under the bill could better be achieved through expanded use of civilian medical schools, and that the Department of Defense could, through agreements with such schools, obtain necessary manpower to meet their needs. We support the scholarship program. We also support the provisions which would modify the existing statutory

restraints on the promotion of medical and dental officers, and would permit such officers to achieve a flag or general officer rank.

The American Medical Association appreciates this opportunity to present its views on H.R. 2.

STATEMENT OF AMERICAN NURSES' ASSOCIATION, INC.

JANUARY 21, 1972.

HON JOHN C. STENNIS
*Chairman, Committee on Armed Services,
U.S. Senate, Washington, D.C.*

DEAR SENATOR STENNIS: The American Nurses' Association, the professional organization of registered nurses in the United States wishes to comment on H.R. 2—Uniformed Services Health Professions Revitalization Act of 1971, and requests that this communication be included in the record of hearings on the bill.

The Association commends you for your long time interest and concern that members of the armed services have available to them health care services of the highest quality.

Our position has been that the Federal government needs to be involved in the total health manpower problem of the nation—civilian and military. Much has been accomplished through enactment of legislation providing financial assistance to schools of the health professions and their students.

Some form of assistance has been available to nursing since 1956 when the professional nurse traineeship program was initiated. Since 1964, legislation to assist schools and students in basic nursing programs has been in force. This program of Federal assistance has been expanded with the passage this past year of The Nurse Training Act of 1971 (P.L. 92-158) and The Comprehensive Health Manpower Act of 1971 (P.L. 92-157).

Opportunities for additional education for qualified registered nurses in the Nurse Corps of the Armed Services are available. Students in baccalaureate and hospital based programs may also receive subsidy on condition they serve a specified period of time in one of the nurse corps. In more recent years, the establishment of the Walter Reed Army Institute of Nursing at the University of Maryland has provided a means by which students can earn a bachelor of science degree with a major in nursing with limited expense to the individual and his family.

This program, supported by the Army but conducted cooperatively with an existing, well-established university seems to us a more preferable pattern that has great recruitment potential for the Army Nurse Corps. Recruitment into the other Services' Nurse Corps is stimulated by the emphasis placed on continuing education, the opportunity to prepare for a specialized field of practice and the encouragement given to perfect skills and increase knowledge. All of these also create an excellent climate for retention of nurses in the various corps.

We believe that the fact that presently most health professionals come into the Armed Services after educational preparation in colleges and universities and experience in many and diverse institutions around the country is bound to enhance and strengthen the contribution they can make to the military.

Although H.R. 2 addresses itself specifically to the need for a university to prepare physicians, we assume that other health professionals would be eligible to enroll in the postdoctoral or postgraduate institutes should these be established by the Board of Regents of the Uniformed Services University of the Health Sciences.

We approve the provision in H.R. 2 that requires that the majority of the members of the Board of Regents and the Dean of the University be drawn from civilian life. We believe this is a safeguard to assure autonomy and avoid any governmental interference that could have the effect of lowering academic standards or infringement of academic freedom.

We would express concern that since appropriations for the support of the various Departments of Government, and their undertakings, must be approved yearly by the Congress, the necessary continuing support of the University might be affected adversely. Adequate authorizations and appropriations for any given program are dependent on the composition and the commitment of the Legislative branch.

Sincerely yours,

EILEEN M. JACOBI, R.N., Ed.D.,
Executive Director.

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION AND THE ASSOCIATION OF SCHOOLS AND COLLEGES OF OPTOMETRY

Mr. Chairman and members of this distinguished Committee: We were honored to have the opportunity to present our comments in support of H.R. 2, "The Uniformed Services Health Professions Revitalization Act of 1972."

The American Optometric Association, with its membership of over 16,000, and the Association of Schools and Colleges of Optometry, representing all twelve optometric teaching institutions wholeheartedly endorse the idea of establishing a comprehensive educational system which will assure an adequate level of health manpower for our military personnel and their dependents.

Military Personnel Vision Care Needs

The need for high-quality vision care from skilled professionals has been widely recognized by the Department of Defense (DoD), the individual branches of the military, and most importantly by members of the Armed Services and their dependents.

Moreover, Congress has demonstrated its awareness of this need, by legislation such as the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), which renders health care to military retirees and dependents, and through administrative rulings within the health programs of the Armed Services, the Civil Service Commission, and other components of the Federal Government.

In testimony before the Committee on Armed Services in the House of Representatives in September, 1971, it was reported that in 1969 almost one-third of all active duty personnel required some type of visual correction, and that a great percentage of all visual care is provided by military optometry officers.

It was also shown in those same hearings that a total of 8,071,952 active duty personnel and their dependents then eligible for such benefits had only 553 optometrists to render this care. These optometrists were divided among three branches of the Armed Forces as follows: Army 315; Navy 68; and Air Force 170.

Distribution of the present 588 vision care practitioners: Army 300; Navy 107; Air Force 181 (190). In addition to these, 12 doctors of optometry are in the Public Health Service Commissioned Corps.

An additional workload for military optometrists results from the 563,544 retirees and their dependents who are also entitled to health care benefits as part of their retirement compensation.

The demand for optometric vision care in the Armed Forces is reflected in the latest statistics which show the following optometrist-to-patient ratios in the various branches of the Armed Services: Army—1:10,635; Navy—1:39,675; and Air Force—1:15,133. In other words, there is an overall average of one optometrist for every 25,000 military-connected patients, compared with the ideal ratio of 1:7,000, which permits the most efficient delivery of professional optometric care in civilian practice.

In December 1971, President Nixon signed into law P.L. 92-129 which, in addition to extending the draft for two more years, granted an extra \$100 per month and Quarters Allowances to all active duty military and PHS Commissioned Corps optometry officers. This Special Pay was also granted to Reserve Optometry Officers in grade O-1 through O-6 who were ordered to active duty before October 1, 1971.

The provision of Special Pay will hopefully improve the retention of military optometry officers, since their salaries are now more nearly on a par with other health professionals in the uniformed services. Also, this special pay provision should help to curb the health practitioner attrition rate, by bringing military compensation more in line with the minimum income levels of private practitioners.

Enactment of the Military Selective Service Act extension represents yet another indication of the awareness of the military establishment and Congress of the need to create and maintain an adequate supply of optometric manpower for the delivery of vision services to military personnel.

Prior to the passage of Special Pay benefits, the relatively unattractive aspects of Armed Services optometric careers were underscored by the fact that on four separate occasions since 1966 it has been necessary to obtain military optometry officers through the process of the Selective Service Act and the "Doctor's Draft" created by Executive Order of the President under that legislation. The most recent requisition of optometrists by the Armed Services required 85 practition-

ers, who were ordered to active duty beginning early in 1971. However, we need not remind the Committee that P.L. 92-129 will terminate the "Doctor's Draft" in mid-1973, and 4,000 military health practitioners will have been dropped this year from the Medical and Dental Corps, in preparation for an all-voluntary military force.

AOA-ASCO Support for H.R. 2

The American Optometric Association and the Association of Schools and Colleges of Optometry concur with the implications of H.R. 2 that the Federal Government does, indeed, have an obligation to undertake the planning and implementation of a program designed to educate and train health professionals for the express purpose of attending to the health and welfare of military personnel and their dependents.

Two beneficial results will surface when the appropriate system is authorized and implemented: 1) the opportunity to include in the curriculum certain course materials which will better prepare each health practitioner to sufficiently deal with health problems encountered in a military setting; 2) for the military and the general health system, the potential which the proposed university holds for attracting young men and women aspiring to engage in military health-care practice, which is almost certain to reduce the present rapid turnover experienced by health units of the Armed Forces.

Students who obtain their professional degrees through the university established by the Uniformed Services Health Professions Revitalization Act would be more motivated to continue a military career than those who are forced to practice for an obligatory service time, which they perceive as an infringement of their opportunity to engage in a more lucrative practice in civilian life.

We might expect three changes to occur as a result of this new approach: 1) better utilization of military health manpower; 2) reduction of the cost of repeatedly training new groups of practitioners to replace those whose tours of duty have ended; 3) potentially better care for military personnel who share a common experience with military practitioners, and thus are better able to relate to one another as regards their health problems.

As mentioned before, the need for a separate and distinct Uniformed Services University of the Health Sciences will become even more evident in light of a pending all-volunteer military service system.

If the Military Selective Service Act must be extended beyond 1973, we would expect that the education of optometrists in a military health academy would eventually obviate the need for recruiting optometric practitioners by means of conscription.

Optometry's Inclusion in a Military Health Academy

The American Optometric Association and the Association of Schools and Colleges of Optometry believe strongly that optometric education should be one of the schools of health in a health academy established by the Uniformed Services Health Professions Revitalization Act of 1972. Such a university would have particular relevance for those optometrists who would be subject to the "Doctor's Draft" and subsequent Executive Orders.

Clearly, any health care service so urgently needed by the military as to necessitate a special draft represents a discipline which must be included in the military health education program. For optometry, a separate and distinct school or college of optometry must be a part of any military health academy, to provide assurance that the vision care needs of the military establishment are met.

Naturally, this optometric component in the proposed system must conform to the existing high standards for accreditation of schools and colleges of optometry, so that the military education would qualify students as eventual candidates for licensure by the various States upon the completion of military service.

Student Selection for the University

AOA and ASCO believe that the scholastic entrance requirements for the proposed university should be at least equivalent to those prevalent in the existing twelve schools and colleges of optometry. This condition should hold true whether optometry students are selected by appointment or some other appropriate means.

Specific provisions should be made in the legislation for selection and education of young persons from economically disadvantaged families, consistent with the current optometric emphasis on minority recruitment. The combina-

tion of these efforts should produce a health care profession truly representative of the diversity of individuals comprising our Nation's population and personnel of the military establishment.

Suggested Options in the Initial Stages

Undoubtedly an appropriately built and staffed facility in a location which affords ready access to related facilities is the best possible situation for the proposed university. Only with a physically separate and free standing facility can an efficient and fully effective method of providing health professionals for the military be accomplished.

If Congress decides to pass this legislation in advance of a suitably constructed facility, we believe that optometry students could be allowed to matriculate into one or more of the existing schools and colleges of optometry on fully paid scholarships and the same pay structure proposed in H.R. 2.

Optometric Manpower Needs; Capacity of Schools; Shortages

A shortage of optometrists in the uniformed services has its parallel in the civilian sector. Some 34,000 optometrists will be needed by the year 1980, as reported by two knowledgeable officials of the Division of Allied Health Manpower, U.S. Public Health Service (later reprinted in the Journal of the American Optometric Association, November, 1970).

Taking into account projected enrollment increases and greater numbers of graduates plus population increases and the normal attrition by death and retirement, we can still foresee a shortage of approximately 12,000 optometrists in 1980 even though the absolute number of practitioners will have increased.

Optometry has compiled a remarkable record of success in attempting to satisfy the increased demand for its practitioners. In the academic year 1964-65, total enrollment in the ten schools and colleges of optometry then in operation was 1,547. By the beginning of the 1973-74 academic year, this number will have increased to 3,366.

This enrollment increase has occurred, in part, because of the judicious application of funds from another Federal source, the Health Professions Educational Assistance Act (HPEA). Recently, appropriations amounting to 72% of authorized funds were approved for the group of health professions schools in which optometry is included. This clearly demonstrates the awareness of Congress that optometry must receive financial support on a par with all other primary health care professions.

Present efforts to expand existing optometric institutions and to construct new facilities will be aided by monies available under the Construction Grants and Financial Distress provisions of the HPEA. However, it is obvious that, even with this limited Federal aid, civilian requirements cannot be met if the supply of optometrists in the private sector is constantly being drained by repeated draft calls for their services in the military forces. Again, the situation is further aggravated by termination of the "Doctor's Draft" in 1973.

Considering all the factors that perpetuate the disparity between optometric supply and demand, we repeat our assertion of several months ago to the House Armed Services Committee: "We support the concept of the Uniformed Services undertaking a system under which optometrists required by the Armed Services are educated by the Uniformed Services."

Additional Comments on H.R. 2

The American Optometric Association and the Association of Schools and Colleges of Optometry feel that a need for subsequent amendments clarifying the scope of instruction to be offered in the proposed university could be avoided if the primary health disciplines were identified in the language of the present bill.

It would seem to be a practical approach to include at the outset those primary disciplines whose practitioners have been called up under the "Doctor's Draft" in the past few years.

However, to permit education of other health care personnel at a later date, the Secretary of Defense and/or the Board of Regents should be given authority to widen the parameters of instruction in the health sciences to include whatever types of health care specialties might be required in the future to provide comprehensive care for military personnel.

We further suggest that the Committee give some thought to specifying that civilians appointed to the Board of Regents must include at least one civilian

from each of the primary health care professions to be taught in the Uniformed Services University of the Health Sciences.

Not all health schools require a total of four years of course work; therefore, the guideline of one year of obligatory service time for each year a student spends in the new university seems to be the most equitable arrangement for the graduates, for the Uniformed Services, and for the American taxpayers.

The American Optometric Association and the Association of Schools and Colleges of Optometry wish to reiterate our support for the concept of establishing a Uniformed Services University of the Health Sciences. We feel strongly that such an institution or system should contain a separate and distinct school of optometry.

With regard to the start-up phase of this effort, we suggest that the university be sufficiently flexible to allow the utilization of existing schools and colleges of the health professions, and that the Board of Regents membership should include at least one civilian practitioner from each primary health care discipline taught in the university.

STATEMENT OF AMERICAN PUBLIC HEALTH ASSOCIATION

DECEMBER 6, 1971.

Hon. JOHN STENNIS,
Chairman, Committee on Armed Services,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I am writing to transmit the views of the American Public Health Association on the Uniformed Services Health Professions Revitalization Act of 1971 (H.R. 2). This legislation has been designed to alleviate the presumed shortage of trained physician and other health manpower to meet military needs at such time as the "doctor draft" is terminated. The bill will attempt to meet this anticipated need in two ways—through creation of a Uniformed Services University of the Health Sciences and through the development of an Armed Forces Health Professions Scholarship Program.

The idea of a military medical school is not a new one. It is based on the supposition that the practice of medicine in the military is significantly different from that in the civilian sector and that the output of such a school would begin to offset a presumed inability to recruit physicians to military service and/or military careers without the impetus of the "doctor draft". In the first instance, there is little evidence that the tasks performed by physicians in the military services are significantly different from those performed by physicians of similar training in the civilian sector. The exception, of course, would be in battle zones during wartime. Experience with previous mobilizations in times of national emergency has shown that physicians without specialized war-zone training performed adequately and admirably in preserving the life and strength of the armed forces. Further, the productivity of such a school in terms of numbers of graduates would not begin to meet the needs of the military, even for legitimate specialized services, and indeed could have a decidedly negative effect by creating a cadre of "academy men" in preferred assignments and positions that would make military careers even less attractive to the graduate of a civilian school who might otherwise consider such a career upon completion of training.

The cost of creating a medical school and making it function effectively to produce quality medical education are well known. In the quest for excellence, the costs of an exclusively military medical school would in all probability far exceed those projected in this legislation. Further, at a time when coordination of health care and training for health careers is being emphasized, the creation of a "specialized" institution would only serve to further fragment the system of health professional education. There are a number of positive steps that could be taken to effectively increase military medical manpower that would not require the type of financial investment that would follow creation of a separate school.

The misutilization of health professionals by the Department of Defense is well-known and probably contributes more to their difficulty in recruiting draft-obligated physicians into career positions than any other factor. A review of the utilization of health manpower by the military conducted by an organization outside government is long overdue. A review of this type, coupled with meaningful reforms in manpower utilization would probably accomplish more in the long run in securing retention of personnel than creation of a free standing military medical school.

The proposed scholarship program represents a more rational approach to securing needed health manpower for the military services. A program of this type, combined with better utilization practices, holds more promise of increasing retention and creating a career service than the military medical school. This program can prove self-defeating, however, if the provisions of Section 2121(C) were to be enacted. We fail to see the effect on the medical competence of the individual of (a) required military training during medical school—an extra burden on an already over-burdened student (b) the attitude of the parent institution toward recruitment activities on its campus or (c) the presence or absence of Reserved Officers Training Corps units in the parent institution.

Neither the goals of quality nor quantity of medical care for the military services would be met by the proposed legislation. Deservedly or not, physicians making a career of military medicine—outside of the “flagship institutions”—have gained a reputation of “second-rate”. To further isolate the military physician during his training period or to selectively assist individuals in institutions which have chosen, for reasons completely unrelated to the quality of the medical education, to exclude certain military activities will do nothing to improve this position.

Sincerely yours,

JAMES R. KIMMEY, M.D.,
Executive Director.

STATEMENT OF AMERICAN VETERINARY MEDICAL ASSOCIATION

JANUARY 19, 1972.

Mr. Chairman and members of the committee, the American Veterinary Medical Association appreciates the opportunity to present its views on H.R. 2, calling for the establishment of a Uniformed Services University of the Health Sciences.

By its title, the proposed university is envisioned as providing for the training of health scientists. We recognize that the principal thrust is directed to producing physicians, to partially satisfy the requirements for those professionals in the military and other Federal agencies. At the same time, we are aware of the substantial number of Doctors of Veterinary Medicine who enter government service from each graduating class of the existing veterinary schools and colleges. We are of the opinion that most of those entering military service are induced to do so by the Doctor Draft, and many of those who elect to remain on active duty do so because of the opportunities for postgraduate training.

Maintaining a high quality of military medical service composed of individuals in the various professional Corps who are selected from a population of volunteers will require inducements competitive with those available in the civilian and private sector. These inducements must be adequate, not only to retain the desired number and quality of individuals as they mature in a career, but, also, to stimulate adequate numbers of younger doctors (physicians, dentists and veterinarians) to initially volunteer for military service.

For the past several years, difficulty has been experienced in obtaining sufficient numbers of health profession officers to fill the requirements of the armed services. Veterinarians have been drafted under the provisions of the Doctor Draft Law. During the past several years, the main source of new officers has been the Early Commissioning Program. This program was successful in producing “volunteers” but, with the lessening of the draft prospect and other factors, the number of students now enrolled in the Early Commissioning Program has markedly declined.

These difficulties will be further accentuated by removal of the pressure of conscription (Doctor Draft). Removal of this stimulus without reasonable compensating inducements is expected to materially decrease the desire of capable young Doctors of Veterinary Medicine to consider, seriously, the career opportunities available for them in the military, when pay, career progression opportunities and individual freedom of choice are more enticing in civilian life.

Retention of veterinary officers is an increasing problem, with the majority of them being retained only when provided advanced training for special assignments. The active force of Army and Air Force military veterinarians is, approximately, 1000 officers. This represents about 4% of the total veterinary profession of the United States. The pressure of the draft has provided a full complement of veterinary officers. However, the low retention of officers beyond their period of active duty commitment has required about 33% of eligible new

graduates to be commissioned, each year, to allow for the fulfillment of military veterinary responsibilities.

Should the Doctor Draft not be continued, other inducements should be available to acquire the veterinary professions needed for military public health and research programs. One of those inducements would be direct Department of Defense support of *professional* and *postgraduate* veterinary education. Although the language of H.R. 2 is not explicit in this regard, it appears to incorporate a fundamental philosophy for providing this support.

The legislation now under consideration might be amended to authorize the establishment of an Armed Forces Health Professions Scholarship Program. The objective of such a program is to insure an adequate number of commissioned officers on active duty who are qualified in the various health professions required, in order to provide proper military medical services for our armed forces.

At the present time, each military department has a program involving a partial subsidization of medical education in return for obligated services. This program could be extended to provide a uniform approach for all services with a specific statutory basis, covering all of the health professions for which there is a need in the military medical services, and which require training beyond the baccalaureate level.

Under the proposed scholarship program, qualified persons accepted by an accredited health professions school, and who would be pursuing an education in one of the health professions, would be granted a commission and ordered to active duty with full pay and allowances and stationed at their respective civilian colleges or universities. In return for this financial assistance, each participant would incur an active duty obligation, the amount of which would be determined under regulations prescribed by the Secretary of Defense.

H.R. 2 does provide that students in the proposed University would be commissioned in "a reserve component of the uniformed services" and students who graduate shall be required to serve on active duty for not less than 7 years. Such a program could be expanded and enacted in existing civilian health professions schools, and could be effective in providing the officer personnel required for the uniformed services. The purpose of the bill could be accomplished through increased support of scholarships for military personnel attending civilian health professions schools.

Inasmuch as we do not believe it is practical to establish a curriculum of veterinary medical training within the Uniformed Services University of Health Sciences, we encourage your Committee to consider broadening the bill to provide for commissioning an appropriate number of students in accredited schools of veterinary medicine and to authorize the Board to negotiate agreements with these institutions to pay for educational services provided students participating in this Department of Defense program. Graduates from this program would be required to serve an appropriate number of years on active duty. This Health Professions Scholarship Program, together with the continuation of the military sponsored postgraduate program now in operation would help to fulfill the officer requirements of the veterinary services in the armed forces.

Again, the AVMA expresses its appreciation for the opportunity to present its views on H.R. 2.

STATEMENT OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES

DECEMBER 2, 1971.

HON. JOHN C. STENNIS,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR STENNIS: The Association of American Medical Colleges has been following with some interest the progress of legislation dealing with the problem of providing an adequate supply of health professionals to meet the health care needs of the armed services. We would like to take this opportunity to comment on certain aspects of the following bills: S 853, introduced by Senator Goldwater; S 1317, introduced by you and Mrs. Smith; and HR 2, introduced by Mr. Hébert and passed by the House on November 3. It is the Association's hope that this letter could serve in lieu of a formal appearance before the Committee and could be made a part of the record of any hearings which occur in these closing days of the first session of the 92nd Congress.

Formed in 1876 to push for reforms in medical college work, the Association has broadened its activities over the years, so that today it represents the whole-

complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 108 operational U.S. medical schools and their students, more than 400 of the major teaching hospitals, and 47 learned academic societies whose members are engaged in medical education and research.

Through its members, the concerns of the Association range far beyond medical education itself. They include the total health and well-being of all of the American people. The Association is concerned with the education and training of persons in other, related health professions and in allied health occupations. It is concerned with the conduct of a substantial portion of the nation's medical and health care research. It is concerned with the delivery of health care, directly through the facilities of teaching hospitals, and indirectly through the development of improved community health services. It is concerned with innovation and experimentation in all of these fields. The Association and its membership thus have a deep and direct involvement in these legislative proposals.

Since 1949, Mr. Hébert, Chairman of the House Armed Services Committee, has pressed for legislation to create a federal medical school for the military services. And for almost as long the Association of American Medical Colleges—as well as most of the other associations of higher education—has opposed such legislation. Many arguments have been cited. Behind much of the opposition has stood the fundamental philosophical question whether establishment of a federal university was in accord with the tradition of American higher education.

Much has changed in the intervening years. The shortage of trained health professionals to meet the health care needs of all Americans—civilian and military—has grown acute.

Yet one important fact has not changed. That is the persistent, fundamental problem of striving to meet the armed services' requirements for health professionals. The resolution of the problem appears to be inextricably tied to increasing the number of well-trained physicians graduated by American medical schools who have an affinity for a career in military medicine and to reducing the turnover rate of career medical officers in the armed services who retire to civilian life.

The Association of American Medical Colleges does not believe that the establishment of a self-contained government medical school would adequately meet either of those objectives. The reasoning behind this belief has been thoughtfully set forth by the prestigious National Academy of Sciences:

"The academic preparation for medicine and other professional careers in health involves a carefully integrated process of education, training, and controlled experience which must be carried out in a broad and diverse community setting which will permit encounter with the full range of diseases, disabilities and health problems. . . . The manner in which this broad community base could be developed for a purely military medical school seems to present a number of difficulties. More importantly, little would seem to be gained from such a step that would compare with the sizable contributions that could accrue both to the nation at large as well as to military needs by continuing the expansion of our existing system of state and privately supported medical institutions for the health professions. It is this series of institutions with their deep community roots and involvement that can provide the soundest base for the development of the highly qualified professionals needed to cope with the full range of health and medical problems, civilian and military."

Rather than dwell further on the reasons for not establishing a self-contained government medical school, the Association most respectfully suggests an alternate proposal which it believes would successfully meet the objectives of increasing the number of health professionals in the armed services and of reducing the turnover rate of career military medical officers. The alternate proposal of the Association is comprised essentially of two interrelated elements.

First is the development of specific programs and arrangements for the matriculation of members of the armed services—and particularly graduates of the several service academies—in civilian schools of the health professions.

Both Mr. Hébert's legislation, HR 2, and Senator Goldwater's bill, S 853 already include the essential authority to link the Defense Department and certain civilian medical schools in an innovation military medical career program. Section 2(g) of each measure authorizes cooperative affiliation agreements with accredited medical schools in the District of Columbia to allow the schools to provide appropriate educational services to health professions students in the armed services. And Section 5 of each measure opens the door to similar agree-

ments in the areas of Portsmouth, Va., San Antonio, San Diego, San Francisco and elsewhere. Broadening and developing these basic authorities could lead to a military medical career program in which graduates of the nation's service academies would be assigned to a Defense Department unit from which they would be accepted as students in cooperating medical schools. Medical schools selected for the program would be located near major military medical installations, which could provide valuable clinical opportunities for the students as well as serve as a source of highly qualified additional faculty.

The Association of American Medical Colleges submits that such a military medical career program would meet the overriding goal of providing trained health professionals for the armed forces. In fact, the Association suggests that such a program could provide more doctors for the armed forces, and provide them quicker and cheaper than would be the case if a new, self-contained government medical school were relied upon. For example, against the graduation after 10 years of 80 physicians annually for the armed services—as envisioned in HR 2 and S 853, a civilian medical school cooperating in a military medical career program could be expected to graduate its first physicians for the armed services after only four years (or three, depending on the school's M.D. curriculum.) One school in the Washington, D.C., area has projected that it could accept 25 first-year military medical students at the beginning of such a program, and has projected a doubling of that first-year enrollment by the third year of such a program. Similar enrollment increases could be expected from other cooperating schools. Furthermore against the anticipated heavy federal expense of starting a new, self-contained medical school—as envisioned in these bills, the government's cost of a military medical career program utilizing civilian schools would be significantly lower.

Current estimates are that start-up costs of new medical schools—even those utilizing some existing facilities—range upward from \$20 million. Government assistance to civilian medical schools enrolling military medical students would likely be on a per-student capitation formula, reflecting the cost of educating such students.

To facilitate the development of such a military medical career program, it is encouraging to note that each of the service academies now offers a specific academic option aimed at providing appropriate preprofessional training necessary for matriculation in health professions schools. Thus a planned educational program leading to a career in military medicine can be selected as a career choice by a cadet on admission to a service academy. The further development of such an option at the service academy level could have broad benefits in attracting individuals with a basic affinity for a military career to the practice of military medicine. Section 6 of Senator Goldwater's bill provides for just such improvement of this academic option.

The second element of the Association's alternate proposal calls for the development of close professional relationships between academic institutions and nearby military programs and installations. If adequately developed, these relationships could provide the setting for a desirable enrichment of military medical life, permitting career military medical personnel to participate in educational and research activities in close association with academic programs.

Suggestions for developing these kinds of relationships have come from the National Academy of Sciences. Its comments deserve renewed attention:

"Steps could be taken to expand in a carefully planned manner the relationships between major DOD medical facilities and adjacent centers of medical research and education. In this fashion a series of university-based educational and research centers could be developed within the defense system of medical installations which would provide the opportunity to bring academic capability to bear upon the problems of military medicine and permit DOD medical officers to enrich their careers through research and teaching in an academic setting in close association with their professional peers."

The National Academy of Sciences went on to point out a number of specific opportunities for the development of cooperative arrangements. It is a tribute to the wisdom and perception of Senator Goldwater and Mr. Hébert that many of the opportunities suggested in their bills also were singled out by the NAS. The Washington area includes a number of medical schools and such major military medical facilities as the National Naval Medical Center in Bethesda, the Malcolm Grow Air Force Hospital at Andrews Air Force Base, the Army's Walter Reed General Hospital and the Armed Forces Institute of Pathology. Similarly, cooperative arrangements could be set up between Letterman General Hospital and the University of California Medical School in San Francisco,

and between the Brooke Medical Center in San Antonio and units of the University of Texas Medical School system, particularly the new school at San Antonio. And finally, both Portsmouth, Va., and San Diego, with their large concentrations of military personnel and dependents, offer opportunities for cooperation with new nearby medical schools.

The Association of American Medical Colleges would like to underscore its sense of responsibility for dealing with the problem of providing adequate health manpower in the armed services. Clearly, it is a particularly complex problem whose solution is indeed elusive. The Association welcomes any opportunity for exploring approaches to educationally sound solutions. And it specifically recommends:

1. Development in the service academies' and other military schools of appropriate preprofessional training necessary for matriculation in health professions schools.

2. Establishment of a military medical career program of cooperative agreements with civilian medical schools.

3. Development of close professional relationships between academic institutions and nearby military programs and installations.

Finally, the Association would like to restate its support for the bill S. 1317, introduced by you and Senator Smith, to establish an Armed Forces Health Professions Scholarship Program. As I indicated to you in an April 6, 1971, letter, the Association considers such a program a positive and useful contribution to the maintenance of an adequate and competent body of health professionals for military service. One provision of the bill does raise a question. As introduced, section 2113(b) would limit the program to four years. Since a number of medical schools currently are experimenting with modified curricula that provide for awarding an MD degree after anywhere from two to six years (instead of the traditional four years), it would seem undesirable to set an arbitrary ceiling on the duration of a scholarship program designated to aid students who may be participating in such an innovative curriculum. As alternatives, perhaps either the Secretary of Defense could be authorized to determine the number of years of courses of study to be included in the scholarship program, or the number of years could be made contingent on the number required to obtain an MD degree from the institution in which a student was enrolled.

Although the House included provisions similar to S. 1317 in H.R. 2, it added one provision—not part of your bill—which is terribly disturbing. This is a proviso in section 2121(c) of H.R. 2 as passed by the House which prohibits scholarship aid for students who attend schools which have barred armed services recruiters from the campus or which have disbanded an R.O.T.C. unit. Such a proviso, if enacted, would limit rather than expand the production of health professionals for the armed services. Furthermore, it would impose an undue financial hardship on someone who had taken no part in (and may even have opposed) the action of a school barring recruiters or disbanding an R.O.T.C. unit. Because of these adverse implications of the House-added proviso, I urge you to omit any such language from the measure you recommend for action by the Senate.

I appreciate this opportunity to comment on legislation dealing with the problem of providing an adequate supply of health professionals to meet the health care needs of the armed services. I and the staff of the Association stand ready to answer any questions that you or the Committee staff may have, and to provide any further assistance that you may desire.

Sincerely,

JOHN A. D. COOPER, M.D.

STATEMENT OF FEDERATION OF ASSOCIATIONS OF SCHOOLS OF THE HEALTH PROFESSIONS

(Dr. Charles W. Bliven, Chairman)

Mr. Chairman, the Federation of Associations of Schools of the Health Professions appreciates this opportunity to go on record in opposition to the provisions of H.R. 2, the Uniformed Services Health Professions Revitalization Act, which would establish a Federal Uniformed Services University of the Health Sciences.

The Federation, which represents eleven associations of health educators, is understandably in sympathy with efforts to educate more health professionals.

But the Federation believes strongly that this should be accomplished through the existing educational system of public and private schools. Establishing a Federal medical school, in our view, would not be conducive to high standards of education. Health professionals should be educated in medical schools, dental schools, schools of nursing and the like. They should be trained as health professionals and not as members of the Armed Forces.

The Federation is also concerned that, at a time when the nation faces an acute shortage of health professionals, establishment of a new school with a rather limited purpose as far as the needs of the nation are concerned would detract from the needs of the existing system.

H.R. 2 is opposed by virtually all major health organizations, including the Association of American Medical Colleges and the American Medical Association.

Health educators represented by the Federation agree that the Armed Forces have a problem obtaining adequate numbers of health care personnel. In a briefing last December, Defense Department officials told representatives of the Federation that of the 14,899 physicians serving in the Armed Forces the previous December, 10,549 had less than four years of service. Almost 9,000 of these had less than two years of service.

The military services are losing medical specialists at a faster rate than they can be replaced. The same problem applies to dentists, the Federation was told by Pentagon officials. But the solution lies not in setting up an elite military medical academy, but in making the military services a more viable career for health professionals who are educated in the nation's existing schools, private and public. Already the Defense Department, under the leadership of Dr. Richard S. Wilbur, Assistant Secretary of Defense (Health and Environment), is undertaking a comprehensive program to enhance the attractiveness of a military career for physicians, dentists and other health professionals. The Federation suggests that this endeavor be given a chance to work before we expend the huge amounts necessary to set up a Federal university for the health professions.

The Federation agrees with the section of H.R. 2 which would establish an Armed Forces Health Professions Scholarship Program. This program would provide professional scholarships for students of medicine, dentistry and other health professions in existing accredited colleges or universities.

Such a means of training health manpower for the Armed Forces would, in the opinion of the Federation, be far more preferable to establishment of a military academy. The nation's schools of the health professions are well able to provide the needed professional training that the military needs in its health care personnel. The necessary military training can be supplied later, incidentally to the individual's proficiency as a provider of health services.

The Senate bill, S. 1317 by Chairman Stennis and Mrs. Smith, is far more suitable to the viewpoint of the Federation of Associations of Schools of the Health Professions than H.R. 2.

Consideration of H.R. 2 should be accompanied by the realization that Congress has just passed a landmark health professions education support program designed to provide the nation with adequate numbers of health care providers by 1980. This carefully designed program will bring much-needed support for the nation's schools for the health professions, new and old, and will help provide a renewed pool of available manpower for the armed forces. Then, it will be up to the Defense Department, aided by the Congress, to find the financial and professional incentives that will attract an adequate corps of skilled health care providers. The Federation believes in the ability of Dr. Wilbur and his capable staff to find the necessary combination to encourage careers in the military services by physicians, dentists, nurses and other health professionals.

It might also be pointed out that the needs of the military services are immediate. The health professionals are needed now when the Armed Forces still are at a peak strength, supplied by the selective service laws. The Federal military health professions school envisioned by H.R. 2 will be graduating some 80 physicians a year 10 years after enactment. It is anticipated that the needs of the military services 10 years from now will be less than they are today.

The Federation believes that the problem of health manpower for the military services should be approached as part of a truly national problem, the need for adequate numbers of professionals to meet the needs of an expanding society and to translate medical research into better lives for the people of this country. To approach the problem merely as a local situation within the Department of Defense would, in the view of the Federation, be a serious mistake.

The need first of all is to ensure that top-quality educational institutions are available for the training of adequate numbers of health professionals and that

means are provided whereby young people desiring to enter the professions and unable to afford the expense have scholarship programs at their disposal. Having aided expansion of the training system, the Federation believes the Defense Department then must find the means to attract adequate numbers of these individuals to volunteer for productive careers in the Armed Forces.

Thus the procurement needs of the military services will be served through a national system that will at the same time be providing improved services to the American people.

STATEMENT OF PRINCE GEORGE'S COUNTY COUNCIL (MARYLAND)

JANUARY 26, 1972.

HON. JOHN C. STENNIS,
Chairman, Senate Armed Services Committee,
Capitol Building, Washington, D.C.

DEAR SENATOR STENNIS: I am writing this letter on behalf of the County Council of Prince George's County, Maryland, which on January 25, 1972, unanimously adopted a resolution supporting Congressman Hébert's H.R. 2, on which the Subcommittee on General Legislation of the Armed Services Committee recently conducted public hearings.

Unfortunately, notice of the hearing date came too late for the Council to have a representative present for the purpose of presenting direct testimony. The Council respectfully requests, therefore, that this letter and the text of Council Resolution 25-1972, which you will find enclosed, be included in the hearing record.

The Council believes this bill, which would establish a "Uniformed Services University of the Health Sciences" within 25 miles of Washington, D.C., merits approval by your committee and by the full Senate.

As stated in Resolution 25, the County Council hopes that the Congress and the Department of Defense would strongly consider a Prince George's County site for the university, if such a teaching institution is authorized.

There is a very serious need for a health sciences teaching facility in Prince George's County, whose 660,000 population makes our county larger than five states. The Council also strongly believes that the proposed university would benefit from affiliation with one of the Washington Metropolitan Area's largest public hospitals, the 650-bed Prince George's General Hospital, new medical centers which have been proposed and from proximity to the College Park and Baltimore campuses of the University of Maryland.

It is our sincere hope that your committee will see fit to move this bill at an early date and that Congressman Hébert's efforts in behalf of the university's establishment, which began more than 20 years ago, will be rewarded with passage by the full United States Senate.

Sincerely,

KENNETH V. DUNCAN,
Administrative Officer.

Enclosure.

COUNTY COUNCIL FOR PRINCE GEORGE'S COUNTY, MD. (LEGISLATIVE SESSION 1972)

Introduced by Councilmen Spellman, White, Francois and Garrity.

Resolution No. CR-25-1972.

Introduced by Council on January 25, 1972.

RESOLUTION

Whereas, by virtue of its House Bill No. 2, the United States Federal Government proposes to establish a "Uniformed Services University of the Health Sciences" within 25 miles of Washington, D.C.; and,

Whereas, such a facility, if it were located in Prince George's County, would not only satisfy the County's need for a health sciences teaching facility, but would benefit by its affiliation with Prince George's General Hospital and new medical centers which are being proposed; and,

Whereas, if such a university were established in Prince George's County, the facilities of the University of Maryland could be utilized to an advantageous degree; and,

Whereas, members of Congress and Defense Department officials need to be contacted by the Prince George's County government alerting them to the merits of locating this proposed project in our County, therefore be it

Resolved By the County Council of Prince George's County, Maryland, that the Administrative Officer to the Council be instructed to obtain immediately from the House Armed Services Committee and, if necessary, the Department of Defense, any site selection criteria that may be available together with information as to when the Senate Armed Services and the full Senate might be expected to act on this legislation, be it further

Resolved That the Administrative Officer be authorized to direct letters to the appropriate members of Congress, including the Chairman of the House and Senate Armed Services Committees, and Department of Defense officials informing them of the Council's support of this bill and of the County's interest in seeing such a facility, if one is established, located in Prince George's County, said letters pointing out the need for health sciences teaching facility in our County and the benefits to the university of being located in proximity to a public medical facility, be it further

Resolved That the Administrative Officer immediately request of the Maryland-National Capital Park and Planning Commission an inventory of available Federally-owned property, particularly those that are already owned by the Department of Defense, specifying that the inventory be in matrix form, if possible, and reflect the desirability of the various available sites as to accessibility, availability of sewer and water utilities, proximity to existing and future public transportation systems and facilities, engineering considerations such as terrain and soil stability, and proximity to hospitals and other health-oriented institutions, be it further

Resolved That the Administrative Officer approach the Economic Development Committee asking that it render assistance in this endeavor.

Adopted this 25th day of January, 1972.

COUNTY COUNCIL FOR PRINCE GEORGE'S COUNTY, MD.
By JOHN B. BURCHAM, Jr.,
Vice Chairman (for Winfield M. Kelly, Jr., Chairman).

Attest:

JEAN M. SCHMUHL, Clerk.

STATEMENT OF DR. MARTIN J. RAFF, UNIVERSITY OF LOUISVILLE (KY.) SCHOOL OF MEDICINE

JANUARY 17, 1972.

Congressman ROMANO MAZZOLI,
Longworth Building,
Washington, D.C.

DEAR CONGRESSMAN MAZZOLI: I would like to call your attention to a recent editorial (copy enclosed) in the New England Journal of Medicine. As a concerned constituent, I want to express my agreement with the author of this article, as well as to add several other points. The need for professional military physicians could be met at much less expense by governmental financial support of three or four medical students in each class in each of the civilian medical schools, with the stipulation that such students serve the government for a given number of years following their graduation. This would provide those schools with full support for at least a small number of students, and would relieve the Treasury of the necessity to build and support a separate institution. It would show the nation's physicians that the Congress was interested in helping to support medical education, by adding financial assistance to schools now facing severe budgetary deficiencies. It would serve to relieve some of the inequities of the physician draft. Since any such "West Point of Medicine" would be certain from the start to meet with opposition from academic medical institutions now in existence, this alternative would provide the military with a corps of medical officers having a diversity of backgrounds, each of whom would be able to maintain a measure of rapport with his parent institution. Thus, the medical profession and civilian academic institutions would be more likely to have a sympathetic attitude toward the military medical corps.

Having been in the Army within the not-too-distant past, and having considered, and rejected out-of-hand the concept of making a career in the service, let me express several other impressions I have gained. The medical services claim that financial inequities are the major reason for their physicians' not

choosing the service as a career. Let me assure you that nothing could be further from the truth. Academic institutional salaries for M.D.'s do not approach what comparable individuals are capable of earning in private practice, and yet their is no dearth of applicants for academic positions. What our military experts fail to realize is that physicians are for the most part, above average in intelligence, relatively independent-minded people who resent having to be treated in an undignified, regimented fashion by individuals who are superior in rank to them, not through medical excellence, but because of longevity. It is more than a little frustrating for a fully trained Obstetrician who is stationed aboard the Cruiser USS Boston to meet a fully trained internist who is functioning as an Obstetrician at an Army base where there is a shortage of Obstetricians. The Internist is in turn frustrated because his opening in Internal Medicine is currently filled by a General Practitioner who happens to have achieved the rank of Colonel because he has been in the service for 18 years. It does not pay to complain, or to write quite logical letters to the Surgeon General's Office, because one suddenly finds himself engaged in very menial tasks, undergoing daily inspections, having requests for leave rejected or inexplicably lost in the mails, or even worse, being transferred out of the command entirely, with Vietnam being the most common threat. The thing the Army tells the Congress about Military Medicine may be as valid as the things they have told them about Vietnam for many years. We were always winning—if we could just have a little more. What needs changing is not the method of obtaining physicians, but the manner in which they are treated once obtained.

The creation of a Department of Military Medicine from which each service could draw physicians who would be responsible to a Surgeon General not promoted to his position through the longevity system would be a desirable change. Secondly, the establishment within that division of a means of promotion based upon medical excellence rather than on degrees of obsequiousness, length of hair, time in service, shininess of shoes or whatever else they currently employ, would also be very helpful in retaining capable personnel. It is unnecessary to "maintain discipline" among physicians, except in rare and unusual cases.

In any event, I quite honestly believe that the establishment of a School of Military Medicine would be a misguided and unnecessary expenditure of governmental resources. I would further suggest that if an intelligent decision is to be made, that Congress make some attempt to assess the feelings of the leaders in American medical education by means of subcommittee hearings of perhaps by polling all the nation's physicians for their opinions on the proposal, as well as attempting to learn their reasons for not having remained in the service at the termination of their obligatory tours of duty.

Thank you for the opportunity to express my opinions in this fashion. I remain,

Respectfully yours,

MARTIN J. RAFF, M.D.,
Chief, Section of Infectious Diseases.

A MILITARY MEDICAL SCHOOL

Do most physicians or most Americans want medical students trained under military auspices? HR 2, "a bill to establish a Uniformed Services University of Health Sciences," is apparently soon to be enacted into law by the Congress. the salient features of the proposal include the development of a medical school within a 25-mile radius of Washington, D.C., the armed forces and other federal hospitals in the area being used as a clinical base. Expenditures of \$100 million are authorized (approximately \$30 million of new construction for offices, laboratories and basic-science departments) by the time the school is required to graduate its first class of no fewer than 100 medical students at the end of 10 years. After graduation, the students will be required to serve on active duty for not less than seven years, although up to 12 per cent of any one class graduating may "agree in writing to perform civilian-federal duty (the nature of this to be determined by the Secretary of Defense) during that time, in lieu of active duty in a Uniformed Service." This section of the Bill also anticipates the development of additional similar schools since the Secretary of Defense is required within five years to make a report to the Armed Services Committees of Congress on the feasibility of establishing "similar or identical educational institutions at any other locations he deems appropriate."

A second section of the Bill establishes an Armed Forces Health Professions Scholarship Program, which will subsidize professional education for a large

number of medical students in established schools. This part of the Program is to be funded at the rate of \$50 million annually (\$20 million in the first year, when an estimated 1500 medical students and 500 dental students would be commissioned on active duty and "detailed" as student officers to accredited civilian institutions in the United States or Puerto Rico). In addition to being accepted to admission to an appropriate school, such a "student officer" would be required to sign an agreement to complete his education, accept reappointment in the military service and, "because of his sincere motivation and dedication to a career in the Uniformed Services, participate in military training while he is in the Program." Those in the Program incur an active-duty obligation for a period to be prescribed by the Secretary of Defense, but for not less than one year for each year in the Program.

The reason given for this proposed legislation is the failure, despite many inducements, of the military services to attract physicians to military careers in sufficient numbers to meet self-determined quotas for medical manpower. Testimony at the hearings on the Bill, September 21-23, 1971 (the source for the following data) indicated that currently 14,899 physicians are in the medical corps of the Department of Defense. Of these, 8738 had two years or less of service (i.e., were primarily draftees), and the remaining 6161 were distributed along a gradually diminishing curve over a range of length of service from just over two to more than 30 years. With these 15,000 physicians the Department of Defense estimates that it provides care to approximately 10 million persons, of whom approximately $\frac{1}{4}$ (2,500,000) are actually serving in the armed forces. (One wonders of what will occur about coverage of the other $\frac{3}{4}$ if a National Health Insurance Program comes into being.)

The scope of this proposal, which may soon encompass up to 10 per cent of all undergraduate medical students, and the suddenness with which it has come to final consideration, will probably catch many physicians and medical educators by surprise. However, aside from the provision that anticipates the development of additional similar schools, it is hard to regard the Bill as a sleeper since this is the 17th version of the proposal introduced in as many sessions of Congress. Representative F. Edward Hébert (D., Louisiana), who became chairman of the House Armed Services Committee on the death of Mr. Mendel Rivers, in his opening statement at the hearings tells of his 25-year-long efforts to bring such a "West Point of Medicine" into being. In its earlier versions the Bill did not come to public attention apparently because it was generally regarded as having no chance of passage. Perhaps it has attracted little notice now because professional associations hesitate to antagonize its powerful sponsor. Outcry and organized opposition have been strangely muted or have been intimidated.

During most of the Bill's history it appeared that the majority of the medical officers in the armed forces were strongly opposed to such a military medical school. However, some physicians in the military and in civilian life as well have promoted it, believing that it would give the health professions in the Department of Defense access to the many benefits of academic medicine and encourage professional self-improvement and continuing education throughout the medical corps of the various services. For this reason, the present version of the Bill comes closer to civilian medical education than earlier versions. It is anticipated that if the Department of Defense had its own medical school, retention of career physicians in the armed forces would be enhanced, and it would be possible to obtain needed physicians without the draft.

The sponsors can have no certainty that these hoped-for effects will be realized. Opponents point out that the above goals are mutually contradictory in that whereas the academic properties that the Department of Defense seeks to capture are those of civilian medical education, it is precisely not a civilian school that is sought. Military medical institutions tend to have at their core a hierarchical and authoritarian ordering of things and ideas that is the antithesis of civilian higher education.

Whether or not anticipated benefits are realized, they need be weighed against offsetting disadvantages such as the consideration that, at a time of limited federal support for medical education when every medical school in the country is stretching to expand enrollments, and when some have seriously overextended their resources in doing so, the anticipated expenditures for one Health Sciences University of \$100 million in start-up costs over a 10-year period, leading to an annual federal appropriation of \$20 to \$30 million for operating costs (exclusive of clinical facilities), would appear to be a serious drain on scarce federal

funds. In comparison, total direct institutional support for all the 108 existing United States medical schools under the Health Professions Educational Assistance Programs during 1971 was \$97.3 million (including \$20.3 million in loans and scholarships, but excluding \$75 million construction for teaching and related facilities).

Furthermore, although not every physician believes that the missions of medicine and those of the armed forces are basically incompatible (and most of those who do believe that to be true recognize that military medicine has made substantial contributions to medical science), I doubt whether many would support the idea that basic professionalization of physicians be carried out in a milieu in which these missions are mixed and in which, in any real showdown, military considerations would have to come first. No amount of political muscle or federal financing should lead us, as a profession, to an acquiescence in an educational scheme that tends to give or appears to give Mars equal status with Aesculapius in the aspirations of nascent physicians. Perhaps the principal objection to a military medical school is that it declares as a public policy that the professional novitiate of one of the most civilized of the professions, embodying what many still believe to be a sacred trust, can be carried out within a military framework losing something of its professional essence.

Finally, we must ask how far we want the military segments of society to penetrate the institutional fabric of national life. The principal argument advanced for founding the school is the need of a special kind of experience or indoctrination during the training of physicians to incline them toward voluntary choice of military careers. But is such a departure really without risk to society? Perhaps an extension of the proposition to absurdity will pose this question most effectively. For example, if we were willing to modify our system of education, no doubt we could make military service more attractive to all our young men. We could condition them as children in grade school and high school as were the youths of Sparta, but the real cost might prove more than our society could afford. It is fundamentally to avoid any such control of higher education that the national associations of higher education have strongly opposed the grating of degrees by the federal government.

The tone of the published hearings in the House Committee and the extremely rapid progression of the Bill through committees and to vote bespeak a managed action rather than deliberative legislative process about a matter of great importance to the medical profession and to all Americans. Opposition was stated in such subdued and conciliatory terms that the issues involved in permanently institutionalizing military medical education (as opposed to more temporary incentives to meet transitory needs) were not clearly defined, much less publicly examined. I believe the medical profession collectively and individually should oppose as rigorously as possible a military medical school. If the profession immediately finds its voice in the matter, the Senate may yet oppose the Bill.

RICHARD M. MAGRAW, M.D.

STATEMENT OF RESERVE OFFICERS ASSOCIATION OF THE UNITED STATES

(Colonel John T. Carlton, Executive Director)

Mr. Chairman and members of the committee, I appreciate this opportunity to make our views known on this important legislation.

The Reserve Officers Association strongly supports the purposes of HR 2, and urges your favorable consideration.

The enactment of this legislation would, at least in part, serve to meet physician requirements of the Armed Services without further depriving the civilian community of needed medical services.

Further it would recognize that the creation of a medical school is a long and arduous process requiring organization, staffing and building and equipment outlay, with attendant high costs.

Moreover it would take into account the existence of major medical resources, military and federal, in the Washington area which can be used for the creation of a major medical education center.

Additionally, and perhaps most importantly, it would provide for an input of medical skills from a now non-existent source, which will be absolutely essential with the thrust for an all volunteer force.

The enactment of this proposed legislation would provide superior medical support for the members of our military services, without sacrificing health services to the members of the civilian community.

I cannot close this statement without bringing to your attention another matter, not a part of the bill before you, but which relates directly to the medical care of our military personnel and their dependents.

A recent memorandum to the Services from the Assistant Secretary of Defense for Health and Environment proposed to reduce drastically the effectiveness of the medical services now provided the military by reduction of the numerical strength of physicians by 40 percent and dentists by 30 percent. A tentative deadline of September 30, 1972 has been set.

We believe this proposal to be in direct contradiction to Defense Department's support of HR 2.

Particularly in the case of physicians this will mean that retirees and dependents will be deprived of most medical care and will have to turn to civilian resources, already stretched to the limit.

Just as important, however, it will mean that military physicians will be caring for only basically healthy individuals between the ages of 17 and perhaps 55. This will deprive them of experience in, for example, obstetrics, pediatrics and geriatrics. The effect on the professional standing of our military physicians and hospitals vis a vis their civilian counterparts is readily apparent.

Primarily the disastrous effect of this proposal on the morale of our military personnel has already been reflected in the almost unanimous negative response from readers of the military-oriented news media.

We would sincerely hope that your committee would look into the potential effects of this proposal on the military forces and their medical services.

In summary, we feel that the professional medical care provided our servicemen and their dependents is vitally important to our national security. Enactment of the bill before you, HR 2, will do much to enhance this care.

STATEMENT OF DR. FRANK W. McKEE, DEAN, SCHOOL OF MEDICINE, WEST VIRGINIA UNIVERSITY, MORGANTOWN, W. VA.

THE UNIFORMED SERVICES MEDICAL ACADEMY

It is apparent in the review of the various topics relating to creation and management of an Armed Services or Uniformed Services Medical Academy, that the basic pattern is that of the Military, Naval, and Air Force Academy, rather than an educational model for essentially humane, and therefore civilian, enterprise. In establishing the other academies under the Department of Defense, it is a fundamental principle that to provide well trained, capable, knowledgeable, and peculiarly adapted leadership for defense enterprise, one must have an educational process that is at wide variance from the ordinary civilian world of a peace loving country. Therefore, all the planning, the personnel, the selection, the training, the obligation incurred, the lasting impact on the individuals concerned are quite different from the comparable educational institution in the United States. While good and sufficient reasons exist for provision of experts in military science, these same reasons do not apply to the medical aspects of the defense establishment.

The military physician, even though in a major way involved with the care and treatment of young healthy men, is also responsible for the general health care of senior officers, senior government officials, military dependents, occasionally for civilian populations in both United States and foreign countries. His background training, understanding of medicine, understanding of the patient with the disease, or injury, are therefore not military but general, and a government sponsored academy to produce a military version of physician, for whatever reason, would be a professional disaster.

There is no need to go into the various anomalies of this eccentric proposal. The possibility of selection of faculty by a governmental official with no qualifications as a medical educator, the possible selection of students by politicians, the possible enormous size of the classes, the indenture period following graduation, all point up to a general atmosphere of an organization that would have very little appeal to anyone conscientiously interested in medical education as a process for producing competent, compassionate, and courageous physicians who are deeply concerned with human suffering and welfare. Beyond the philosophical

considerations, which would be laughable if they were not so deadly serious, are matters of impact on a system already reeling under blows of manpower shortage and rising costs with insufficient financial support, which the Congress in its wisdom has failed to heed. To confront the medical education of the United States with a well-heeled, special interest, politically operated competitor at this point in time would be a catastrophe. To establish such an institution in the National Capital area in which every school—Howard, Georgetown, George Washington, University of Virginia, University of Maryland—is under serious strain in both faculty recruitment and operational and facility support would be an individual and collective disaster to these national resources. I have omitted Johns Hopkins University, which is under grave financial pressure but manages the recruitment of faculty because of its long standing reputation for excellence. On the other hand, if the purpose of the uniformed services school is to generate a competent ready-made faculty, this destructive influence on existing schools will be a god-send.

A final point in this discussion would be the accreditation of the school and its place in the community of medical education. The responsibilities of the Federal Government are for the general welfare of the entire population, and provision for this general welfare by defense and military activity is only one part. As I have stated, the three military academies offer no particular concern to the rest of the educational establishment, because of their select purpose which is of little general interest to those genuinely devoted to education. The medical education family is, however, smaller, more select, more devoted to a special purpose which is anything but military. It has, however, in the past supplied personnel, know-how, and support for the armed forces, and the writer has been a participant in this endeavor. But it is extremely vulnerable, now in this period of burgeoning population and demand for medical care and dwindling federal support. It would seem more reasonable for the military to pump its support into the existing system, making whatever commitments it feels are necessary, rather than laying this cowbird's egg in the nest of an already strained system so completely necessary to our national well-being.

A uniformed service medical academy is an ill-conceived proposal, philosophically, socially, and financially because of its deleterious impact on the health manpower of the entire country. Beyond that, it is totally out of step with the general principles and purposes of this democracy and contaminates a profession, presumably dedicated to a broad policy of alleviation of human distress, with a flavor of militarism and antithetic purpose. One would hope for a solution to the relatively insignificant needs of military medicine, as compared with the devastating problems of the country as a whole, by a better conceived approach, more consonant with national principles, beliefs, and goals and less ominous in the spirit of our times.

FRANK W. MCKEE, M.D.,

Dean, School of Medicine, West Virginia University.

QUESTIONS SUBMITTED BY SENATOR BYRD, CHAIRMAN OF THE SUBCOMMITTEE ON GENERAL LEGISLATION, TO THE DEPARTMENT OF DEFENSE FOR INCLUSION IN THE RECORD, AND ANSWERS SUBSEQUENTLY FURNISHED

Question. One of the witnesses appearing before the Subcommittee made a comparison between the \$97.3 million which he indicated the Federal government spent in 1971 under the Health Professions Educational Assistance Program in direct institutional support for the existing U.S. medical schools and the estimated \$100 million start-up costs of the proposed Uniformed Services University of the Health Sciences. Would you comment on this comparison?

Answer: First of all, the witness was comparing one year's expenditures under one program with the aggregate of 10 years' of expenditures under the other. Secondly, the witness himself indicated that the \$97.3 million figure excluded \$75 million in construction funds contributed by the Federal government under the program in question. If the data are correct, it is obvious the total Federal expenditures under that program for 1971 amounted to \$172.3 million. In any event, the Federal government's annual expenditures under the Health Professions Assistance Program represent but a small fraction of the total contribution which the Federal government makes annually to U.S. medical schools. For example, according to the American Medical Association (page 1225 of the 22

November 1971 issue of the *Journal of the American Medical Association*), the total funds contributed to U.S. medical schools by the Federal government for the academic year 1969-70 amounted to \$747.6 million. This amount is approximately half of the \$1,549.5 million of the medical school total financial support for that academic year reported in the *Journal*.

Question. The statement for the Record submitted to the Subcommittee by the President of the Association of American Medical Colleges expressed concern regarding the provisions of the bill which would limit participation in the scholarship program to courses of study of not more than four years duration. The basis for his concern is the changing curricula of a number of medical schools that permit the award of an M.D. degree after anywhere from 2-6 years instead of the traditional 4-year period. In view of the present experimentation in medical school curricula, do you consider it wise to retain the 4-year maximum provision now in the bill?

Answer. No. We believe the Doctor Cooper's point is well taken. We suggest that the Subcommittee consider an appropriate amendment to section 2121(b) which would remove the present 4-year maximum.

Question. Has the Department of Defense ordered a 40 percent reduction in the number of military physicians in the armed forces?

Answer. No. Recent articles in the press, from which it could be concluded that the actions referred to above have already been taken, appear to be based upon incomplete information regarding a joint study now being conducted by the Department of Defense and the Department of Health, Education, and Welfare of practicable means of meeting the medical needs of the armed forces which would require less dependence on military medical personnel. This study was directed by the Congress. The requirement that the study be made is contained in section 101(c) of Public Law 92-129, which is the recently enacted draft extension law. The new law also specifies that, as a part of the study, special consideration shall be given to the feasibility of using civilian clinics, hospitals and individual members of the medical profession at or near U.S. military installations within and outside the United States. The law further requires that the Secretaries of the two Departments in question shall submit to the Congress the results of the study, together with appropriate recommendations, not later than 29 March 1972. The first goal of the Department of Defense is the provision of the highest possible quality of health care of all of our beneficiaries.

Our second goal is the achievement of an all-volunteer health service as a part of the Administration's goal of achieving an all-volunteer force. Such a goal is desirable because an organization made up of persons who wish to be members is more valuable than one consisting of persons who are forced to be members. A patient is happier when a doctor who wants to be in the military is caring for him rather than one who has been forced to leave civilian life for military practice. Our third goal is increased efficiency. At present our Medical and Dental Corps total nearly 20,000 of whom about one-third are lost each year. With the end of the draft, the number of these professionals will be fewer. At that time we believe the Medical and Dental Corps should be almost entirely comprised of highly skilled and dedicated career professionals, better paid, more professionally satisfied, better motivated, more efficient and most of all, better able to deliver the highest quality of health care without diminishing the quantity to all for whom we are responsible.

Question. You state that your present limited scholarship program has been highly successful. How successful has it been?

Answer. We believe that it has been very successful to date. However, we would note that the programs are relatively recent and we have not had sufficient experience to judge the retention rate of the graduates of the scholarship program. The Army and the Air Force started their programs in Fiscal Year 1967 and each had a few graduates of the program in that year because some graduates entered the program as seniors. While both the Army and Air Force are receiving a greater number of graduates each year (FY 71—40 for the Army and 68 for the Air Force), all of the graduates are still serving some form of obligation. The Navy began its program in FY 71 and it has not yet had a graduating group. Consequently, we do not know how many will eventually stay for a complete career but we do know that the vast majority of graduates are either in or anticipating entering a residency training program while in the military and that this is an indication of a desire to remain longer than their basic obligation

for the scholarship program. In spite of our lack of experience concerning retention, we can still characterize the program as extremely successful because of the large number of highly qualified applicants for the program, the general quality of the students in the program, and the extremely small attrition from the program. It was from the experience with this program that the conclusion was drawn that the Department of Defense would be able to attract large numbers of students in the health professions into the military service through a scholarship program.

Question. The phrase "educational services" appears three times in the bill. What is your understanding of the meaning of that phrase within the context of the bill?

Answer. The number of students involved in the proposed scholarship program is quite large. We believe that in some instances it may be desirable for us to attempt to reach an agreement with a school, such as a medical or dental school, under which they would take Department of Defense scholarship participants into their school as additions to their own student body. This, of course, would pose a financial problem for the school in that medical school tuition and fees do not cover the expense of educating medical students. They operate at a substantial deficit, consequently we would, in effect, be asking the school to subsidize our procurement program. The phrase "educational services" is intended to mean the amount that we would have to pay to such a school for their added expenses as a result of adding our students to their program. We would not expect to pay for the deficit for a student merely because he joined our program if he was already accepted for or pursuing studies in a school.

Question. What percentage of your medical scholarship participants would you need to retain as career Medical Corps officers in order to solve your career retention problem?

Answer. We cannot answer this question precisely since there are two variable factors involved. The first is the degree of success we achieve with respect to our other procurement programs including their retention rates. The second variable is the question of what the size of the active force will be, for example, nine years from now when the first full participants in the proposed program would have completed their four years of school, one year of internship and four years of payback time. It is our belief at present that a retention rate of 50 percent during the early years involved (from approximately 1980 to 1985) and a 25 percent rate thereafter would probably meet our career needs. We would note that these retention rates are for a full military career. We would certainly expect that the vast majority of the scholarship participants would remain on active duty beyond their initial obligation for the purpose of residency training and that, as a result, they would serve for from five to 10 years as military physicians rather than the four years the bill would require.

Question. Section 2116 of the proposed amendments to title 10 that are contained in H.R. 2 would require the Department of Defense to report to the Congress on the feasibility of establishing additional health science universities at other appropriate locations. What other geographical areas do you have in mind?

Answer. We have not yet selected any other areas for consideration in this regard.

Question. Please comment on the provisions of the bill which would exclude from participation in the scholarship program, all students who are attending a school that has disestablished an ROTC unit or which bars armed forces recruits from its campus.

Answer. We do not believe that qualified applicants for participation in the proposed scholarship program should be denied such participation on the grounds that they are enrolled in a medical school that is part of a university which has disestablished an ROTC unit. We believe that many of these students strongly support, or are sympathetic to, our country's national security goals. In addition, we are anxious to have as broad a medical school base as possible for our program in order to increase the likelihood of meeting our procurement goals.

QUESTIONS SUBMITTED BY SENATOR DOMINICK TO THE DEPARTMENT OF DEFENSE FOR INCLUSION IN THE RECORD, AND ANSWERS SUBSEQUENTLY FURNISHED

Question. What other proposals were studied that offered a possibility of solving the M.D. shortage in the Armed Services? Why were these proposals rejected?

Answer. We firmly believe that there is no one solution to the career M.D. shortage problem of the armed services. We have studied (and are continuing to study in some instances) a combination of various proposals which we believe may assist us in solving this problem. These include the following:

- A massive scholarship program.
- Increased pay.
- Continuing medical education.
- Lowering the amount of administrative responsibility for senior physicians.
- General and flag officer rang for outstanding clinicians who could continue in that capacity.
- More, and even better trained, paramedical personnel.
- Increased clerical support for health professionals.
- New equipment and improved treatment facilities.
- Improved personnel management.

Question. After the USUHS is established and graduates from this institution have served their mandatory time, what retention rate do you anticipate? Compare this forecast retention rate to doctors who presently volunteer to serve in the Armed Services.

Answer. It is difficult to forecast retention rates for a particular category of personnel 10-15 years into the future. Most of the participants in the USUHS program would seek and obtain specialty training following graduation from the University and would thereby incur varying amounts of additional obligated service beyond the minimum seven years specified in the bill.

Our best estimate at present is that we would retain approximately 50 percent of the USUHS graduates.

At the present time we are retaining less than one percent of the two-year noncareer physicians in the armed forces. Of those physicians who participate in our military residency training programs, we are retaining between 25-30 percent.

Question. Using today's pay scales, what pay would a USUHS graduate be receiving at the time he completed his mandatory service? What would his rank be?

Answer. If a USUHS graduate did not undergo any specialty training and is only required to perform the minimum amount of payback time specified in H.R. 2, he would be a major/lieutenant commander when he completed his mandatory service and his annual pay would be \$19,000. On the other hand, if he undergoes specialty training and incurs an additional obligation, his grade and annual pay at that time would be lieutenant colonel/commander and \$30,000, respectively.

Question. If the annual number of graduates from the USUHS is 100, what percentage of the Armed Services annual requirement do you anticipate this will be?

Answer. Assuming that the armed forces remain at present projected levels of 2.3 million and that we have a successful career retention program, the USUHS graduates would constitute approximately 15 percent of our annual requirements.

Question. Why would not an expanded medical scholarship program meet the annual Armed Services requirement if the government entered into expansion programs with selected civilian medical universities?

Answer. An expanded medical scholarship program could meet our annual requirements if we were able to retain almost all of the participants; however, since we do not anticipate achieving that retention level, we will still need additional programs in order to meet our overall requirements. Moreover, the intended role of the USUHS is not limited to the procurement function. I would be the focal point for all health education programs. We think that it would

also significantly improve retention if some of our leading physicians were able to achieve academic standing within the military system instead of having to seek it elsewhere.

Question. If the AMA is opposed to the establishment of a USUHS, what is the major objection, as you know it? Has the AMA offered an alternative proposal?

Answer. We, of course, are in no position to speak for the AMA. It is our understanding that the AMA has not submitted to your Subcommittee a statement regarding its position on the establishment of a USUHS. They did, however, present testimony before the House Armed Services Committee on this question. The following is quoted from that testimony:

"In our opinion, it would be very unwise to establish a separate medical school specifically to train physicians for the uniformed services in which all, or a significant portion, of the physicians serving in these forces would receive their medical training. We believe it is very important that the Armed Forces take full advantage of the resources and facilities of the existing medical schools of the United States in training their own medical manpower, and that such training not be restricted in any degree to a single school established for that purpose. We also believe that it would be possible to train larger numbers of physicians in a shorter period of time, for a lesser cost if the existing schools are used."

We are not aware of any alternative proposal other than the use of existing schools as quoted above.

Question. What is the anticipated cost of the institution? What are the annual operating costs anticipated to be?

Answer. The estimated start-up costs of the institution over a 10-year period are \$101.7 million; annual operating costs thereafter are projected at approximately \$21 million.

Question. Would the man in charge of USUHS be a civilian or military officer? Would he be a doctor or a medical administrator? To whom would he report in the DoD chain of command?

Answer. The bill does not specify whether the head of the USUHS would be a civilian or a military officer. Presumably, therefore, he could be either. We would anticipate selecting the best qualified person available for the position who might be either a civilian or a military officer. Under this concept and over the years we anticipate that selections would be made from both types of personnel.

While there are from time to time a few non-M.D.'s who are deans of U.S. medical schools, the vast majority of persons in those positions hold the M.D. degree. We think it highly likely that the person selected to fill this position would be an M.D.

The dean would be appointed by and would be primarily responsible to the Board of Regents contemplated by the bill, the members of which would be appointed by the President by and with the advice and consent of the Senate. Within the DoD chain of command, we contemplate that the dean would report to the Assistant Secretary of Defense (Health and Environment).

Senator BYRD. If there is no further business, the subcommittee will stand adjourned.

(Whereupon, at 11:55 a.m., the hearing was adjourned, the subcommittee to reconvene subject to the call of the chair.)



