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**EXTENSION OF THE DISTRICT OF COLUMBIA MEDICAL
AND DENTAL MANPOWER ACT OF 1970**

GOVERNMENT
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HEARINGS

BEFORE THE

**SUBCOMMITTEE ON LABOR, SOCIAL SERVICES,
AND THE INTERNATIONAL COMMUNITY**

OF THE

**COMMITTEE ON
THE DISTRICT OF COLUMBIA
HOUSE OF REPRESENTATIVES**

NINETY-THIRD CONGRESS

SECOND SESSION

ON

**H.R. 11108, H.R. 11186, H.R. 11207,
AND H.R. 11535**

**TO EXTEND FOR THREE YEARS THE DISTRICT OF COLUMBIA
MEDICAL AND DENTAL MANPOWER ACT OF 1970**

JANUARY 24, 1974



U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1974

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CONTENTS

H.R. 11108 (Mr. Diggs et al.), to extend for 3 years the District of Columbia Medical and Dental Manpower Act of 1970-----	Page 1
H.R. 11186 (Mr. Patten), companion bill-----	1
H.R. 11207 (Mr. Flood et al.), companion bill-----	1
H.R. 11535 (Mr. Rogers et al.), companion bill-----	1
Staff memorandum-----	2-3

STATEMENTS

American medical colleges, statement-----	116
American Medical Society of the District of Columbia-----	124
Ball, Dr. Michael, director, Division of Biomedical Research and Faculty Development, Association of American Medical Colleges; accompanied by Prentice Bowsher, director of Division of Federal Liaison-----	121
Broyhill, Hon. Joel T-----	36
Callahan, John, D.D.S., president, District of Columbia Dental Society--	126, 127
Cohill, Orren T., vice president of the Interim Advisory Board of Northeast Georgetown Medical Center-----	145
Department of Health, Education, and Welfare:	
Endicott, Kenneth M., M.D-----	7
Greene, John C., D.M.D-----	7
Zapp, John S., D.D.S-----	7
District Government:	
Robinson, William, Chief of the Legislation and Opinions Division--	43
Standard, Raymond L., M.D., M.P.H., Community Health and Hospital Administrator and Director of Public Health-----	43
Georgetown University:	
Henle, Rev. Robert J., S.J., president-----	53
McNulty, Matthew F., Jr., SC. D., executive vice president-----	62
Murto, Charles B., D.D.S., dean, School of Dentistry-----	75
Utz, Dr. John P., dean, School of Medicine, presented by Clifton Himmsbach-----	73
George Washington University:	
Elliot, Lloyd H., M.D., president-----	91
Feffer, James J., M.D., vice president for medical affairs-----	93
Gruver, Dr. Clifton R., president, Medical Society of the District of Columbia-----	125
Gude, Hon. Gilbert-----	6
Kennedy, Kenneth C., member, Education Committee, D.C. Branch, National Association for the Advancement of Colored People-----	132
Melnick, Vijaya, Ph. D., assistant professor of biology and premedical adviser, Federal City College-----	144
Wolfe, Ava, M.D., member, D.C. Chapter Steering Committee of the Medical Committee for Human Rights-----	134, 141

MATERIAL SUBMITTED FOR THE RECORD

Alpert, Seymour, M.D., vice president, George Washington University, letter to Congressman Mazzoli, dated Feb. 6, 1974-----	107
Bruce, Harry W., Jr., director, Division of Physician and Health Professions Education, letters to Dr. James J. Feffer, George Washington University and to Dr. Matthew F. McNulty, Georgetown University, dated Feb. 28, 1974-----	21, 22
Department of Health, Education, and Welfare:	
Zapp, John S., D.D.S., letter to Congressman Mazzoli, dated Feb. 22, 1974-----	14, 173
Statement-----	15
AAMC summary of State roles in the financing of medical education-----	18

Feffer, James J., M.D., vice president for medical affairs, George Washington University, letters to Congressman Mazzoli, dated Feb. 1, 1964	106, 165
Howard University:	
Alexis, Dr. Carlton P., vice president for health affairs, letter to Dr. Seymour Alpert, George Washington University, dated Mar. 16, 1970	4
Cheek, James E., president, letter to Congressman Mazzoli, dated Jan. 22, 1974	4
McNulty, Matthew F., SC. D., executive vice president for medical center affairs, George Washington University, letter to Congressman McNulty, dated Feb. 1, 1974	108
Washington, Hon. Walter E., Mayor-Commissioner, letter to Chairman Diggs, dated Jan. 24, 1974, reporting on the legislation	45

SUMMARY OF TESTIMONY

Amendment proposed	51, 124, 141, 144
Community involvement	54
Community relations	148, 155
Community services	73, 75, 78, 126, 132, 142, 146
Costs	33, 72, 74, 98, 153
District of Columbia contracts	112
District of Columbia Medical and Dental Manpower Act	7
District of Columbia Medical Schools	26, 29
District problems	23
District service areas	46
District students	22
Education funding	80
Faculty	71, 76, 125
Federal programs	11
Federal support	122
Financial distress funds	12, 30, 32, 34, 60, 83, 100, 115
Financing	68, 114, 121
Financial plight of schools	53
Funding	101, 133, 151
Georgetown and George Washington Medical Schools	50
George Washington facilities	114
Graduates	29, 76, 81, 97, 104, 112, 127, 155
Health Manpower Act	36, 84
Health Manpower Training Act of 1971	123
Health training programs	125
HEW oversight	85
HEW recommendation	9, 11
Howard University	31, 47, 112
Jurisdictional question	61, 86, 103, 123, 129
Labor relations	152
Legislation required	28
Medical Association's recommendations	128
Minority students at the George Washington University	107
Needs	44, 52, 74
Paramedical program	105, 150
Pending legislation	8
Plight of District of Columbia medical and dental schools	10
Practice plan	99
Present considerations	13
Present programs	9, 59
Public Health Services Act	44
Public medical college	89

	Page
Nursing schools.....	77
Scope of hearing.....	4
Scope of services.....	41, 67
State programs.....	8, 102, 113, 115, 119, 122
Students.....	60, 68, 69, 73, 76, 94, 95, 101, 106, 107, 109, 143, 144, 147, 149, 154
Tuition	110
Tuition grants.....	89
University services.....	96

1. The first part of the paper is devoted to a general
 introduction of the subject and to a statement of the
 main results. The second part is devoted to the
 proof of the main results. The third part is devoted
 to the proof of the main results. The fourth part is
 devoted to the proof of the main results. The fifth
 part is devoted to the proof of the main results.

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APPENDIX

STATEMENTS

American Dental Association and the American Association of Dental Schools -----	Page 160
Buchner, William M., executive vice president and director, Hospital Council of the National Capital Area, Inc.-----	159
Cleary, Dr. Robert E., provost of the American University-----	163
Edwards, Minnie Bock, vice president of the Central Northeast Civic Association of the District of Columbia for General Support of Georgetown University School of Medicine-----	161
Johnson, Henry J., Jr., president of Rogers Memorial Hospital's chaplains staff -----	162
Response to statements specifically referring to Georgetown University School of Dentistry and exhibits-----	207
Rogers, Paul, Washington, D.C.-----	157

COMMUNICATIONS

Browne, Ms. Veronica, Area C Policy Board, memorandum to Congressman Mazzoli, dated January 24, 1974-----	165
Feffer, Dr. James J., Georgetown University, letter (including enclosures) to Congressman Mazzoli, dated February 7, 1974-----	165
Fauntroy, Hon. Walter E., letter to Congressman Mazzoli, dated January 24, 1974-----	158
Howard, Dr. Ernest B., American Medical Association, letter to Congressman Mazzoli, dated January 23, 1974-----	163
Nicholls, Dr. Kenwyn H., health services director, Northeast-Georgetown Medical Center, letter to Congressman Mazzoli, dated January 23, 1974--	164

APPENDIX

101	1. The first of the three main divisions of the subject is the history of the subject.
102	2. The second of the three main divisions of the subject is the history of the subject.
103	3. The third of the three main divisions of the subject is the history of the subject.
104	4. The fourth of the three main divisions of the subject is the history of the subject.
105	5. The fifth of the three main divisions of the subject is the history of the subject.
106	6. The sixth of the three main divisions of the subject is the history of the subject.
107	7. The seventh of the three main divisions of the subject is the history of the subject.
108	8. The eighth of the three main divisions of the subject is the history of the subject.
109	9. The ninth of the three main divisions of the subject is the history of the subject.
110	10. The tenth of the three main divisions of the subject is the history of the subject.
111	11. The eleventh of the three main divisions of the subject is the history of the subject.
112	12. The twelfth of the three main divisions of the subject is the history of the subject.
113	13. The thirteenth of the three main divisions of the subject is the history of the subject.
114	14. The fourteenth of the three main divisions of the subject is the history of the subject.
115	15. The fifteenth of the three main divisions of the subject is the history of the subject.
116	16. The sixteenth of the three main divisions of the subject is the history of the subject.
117	17. The seventeenth of the three main divisions of the subject is the history of the subject.
118	18. The eighteenth of the three main divisions of the subject is the history of the subject.
119	19. The nineteenth of the three main divisions of the subject is the history of the subject.
120	20. The twentieth of the three main divisions of the subject is the history of the subject.

EXTENSION OF THE DISTRICT OF COLUMBIA MEDICAL AND DENTAL MANPOWER ACT OF 1970

THURSDAY, JANUARY 24, 1974

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LABOR, SOCIAL SERVICES,
AND THE INTERNATIONAL COMMUNITY OF THE
COMMITTEE ON THE DISTRICT OF COLUMBIA,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:10 a.m., in room 1310 Longworth House Office Building, Hon. Romano L. Mazzoli, presiding.

Present: Representatives Mazzoli, Stark, Nelsen, and Gude.

Also present: Representatives Dellums and Broyhill.

Also present: Dorothy E. Quarker, chief of staff; John E. Hogan, minority counsel; Leonard J. Hilder, minority professional staff; Ralph Ulmer, minority professional staff; J. D. Kirschten, subcommittee consultant; Karen Fleischer, research assistant; and Joseph Clair, subcommittee counsel.

Mr. MAZZOLI. The hearing will please come to order.

Ladies and gentlemen, we are here this morning to discuss H.R. 11108, a bill to authorize special Federal subsidies for private, non-profit, accredited medical and dental schools located in the District of Columbia. The legislative history of this bill shows it is intended primarily to provide fiscal relief for the George Washington University School of Medicine, and the Georgetown University Schools of Medicine and Dentistry.

[H.R. 11108 and companion bills follow:]

H.R. 11108, 93d Cong., First Sess., by Mr. Diggs (for himself, Messrs. Nelson, Stuckey, Dellums, Rees, Fauntroy, Howard, Rangel, Breckinridge, Stark, Broyhill of Virginia, Gude, Landgrebe and McKinney), on October 25, 1973.

H.R. 11185, 93d Cong., First Sess. by Mr. Patten on October 30, 1973.

H.R. 11207, 93d Cong., First Sess. by Mr. Flood (for himself, Messrs. Kyros, Mann, Carter, Parris, Conte, Shriver and Hastings) on October 31, 1973.

H.R. 11535, 93d Cong., First Sess. by Mr. Rogers (for himself, Messrs. Jones of Oklahoma, Roy, Symington, Hansen of Idaho, Preyer, Mrs. Green of Oregon, and Mr. Brown of Michigan) on November 15, 1973.

BILLS To extend for three years the District of Columbia Medical and Dental Manpower Act of 1970

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 303(c) of the District of Columbia Medical and Dental Manpower Act of 1970 (D.C. Code, sec. 31-922) is amended by inserting "and for fiscal years 1975, 1976, and 1977" immediately after "1972."

(b) Section 303(b) of such Act is amended by striking out "section 772 of the Public Health Service Act (42 U.S.C. 295f-2)" and inserting in lieu thereof "section 773 of the Public Health Service Act".

MEMORANDUM RE D.C. DENTAL AND MANPOWER ACT OF 1970 (D.C. CODE, TITLE 31, SEC. 921 ET SEQ.)

SUBCHAPTER II.—FINANCIAL ASSISTANCE

§ 31-921. *Purpose.*

It is the purpose of this subchapter to assist private nonprofit medical and dental schools in the District of Columbia in their critical financial needs in meeting the operational costs required to maintain quality medical and dental educational programs and to increase the number of students in such institutions as a necessary health manpower service to the metropolitan area of the District of Columbia. (Jan. 5, 1971, Pub. L. 91-650, title III, § 302, 84 Stat. 1934.)

SHORT TITLE

Section 301 of title III of act Jan. 5, 1971, Pub. L. 91-650, provided: "This title (enacting §§ 31-921 to 31-929) may be cited as the 'District of Columbia Medical and Dental Manpower Act of 1970'."

SEPARABILITY, AUTHORITY OF COMMISSIONER AND COUNCIL, DELEGATION OF FUNCTIONS, AND SAVINGS PROVISIONS OF PUB. L. 91-650

See secs. 801-803 of act Jan. 5, 1971, Pub. L. 91-650, set out as a note under § 47-2501a.

§ 31-922. *Authorization of grants to Commissioner—Limitations—Appropriations authorized.*

(a) The Secretary of Health, Education, and Welfare (hereinafter in this subchapter referred to as the "Secretary") is authorized to make grants to the Commissioner of the District of Columbia (hereinafter in this subchapter referred to as the "Commissioner") in amounts the Secretary determines to be the minimum amounts necessary to carry out the purposes of this subchapter. The total amount of grants under this section for any fiscal year shall not exceed the sum of (1) the product of \$5,000 times the number of full-time students enrolled in private nonprofit accredited medical schools in the District of Columbia, and (2) the product of \$3,000 times the number of full-time students enrolled in private nonprofit accredited dental schools in the District of Columbia.

(b) For the purposes of this section and section 31-926, in determining eligibility for, and the amount of, grants with respect to private nonprofit medical and dental schools, consideration shall be given to any grants made to such schools pursuant to the portion of the program under section 772 of the Public Health Service Act (42 U.S.C. 295f-2) relating to financial assistant to schools which are in serious financial straits to aid them in meeting their costs of operation.

(c) There are authorized to be appropriated \$6,200,000 for the fiscal year ending June 30, 1971, and such sums as may be necessary for the fiscal year ending June 30, 1972, to make grants under this section. (Jan. 5, 1971, Pub. L. 91-650, title III, § 303, 84 Stat. 1934.)

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 31-923, 31-924, 31-925, 31-926.

§ 31-923. *Application for grants—Time for filing—Contents.*

The Secretary may from time to time set dates by which applications for grants under section 31-922 for any fiscal year must be filed by the Commissioner. A grant under section 31-922 may be made only if application therefor—

(1) is approved by the Secretary;

(2) contains such information as the Secretary may require to make the determinations required of him under this subchapter and such assurances as he may find necessary to carry out the purposes of this subchapter; and

(3) provides for such fiscal control and accounting procedures and reports and access to the records of the Commissioner and the applicant schools as the Secretary may from time to time require in carrying out his functions under this subchapter. (Jan. 5, 1971, Pub. L. 91-650, title III, § 304, 84 Stat. 1934.)

§ 31-924. *Regulations to prescribe basis for determining number of students.*

For the purposes of section 31-922 and section 31-926, regulations of the Secretary shall include provisions relating to the determination of the number of

students enrolled in a school, or in a particular year-class in a school, as the case may be, on the basis of estimates, or on the basis of the number of students who were enrolled in a school, or in a particular year-class, as the case may be, in an earlier year, or on such basis as he deems appropriate for making such determinations. (Jan. 5, 1971, Pub. L. 91-650, title III, § 305, 84 Stat. 1934.)

§ 31-925. *Method of paying grants under § 31-922.*

Grants under section 31-922 may be paid in advance or by way of reimbursement at such intervals as the Secretary may find necessary and with appropriate adjustments on account of overpayments or underpayments previously made. (Jan. 5, 1971, Pub. L. 91-650, title III, § 306, 84 Stat. 1934.)

§ 31-926. *Commissioner to make payments to medical and dental schools—Limitations.*

From funds received under section 31-922, the Commissioner shall make payments (in amounts determined by the Secretary under such section 31-922) to private nonprofit schools of medicine and dentistry in the District of Columbia. The total of the payments under this section in any fiscal year to a medical school shall not exceed the product of \$5,000 times the number of full-time students enrolled in such school, and the total of payments to a dental school shall not exceed the product of \$3,000 times the number of full-time students enrolled in such school. (Jan. 5, 1971, Pub. L. 91-650, title III, § 307, 84 Stat. 1934.)

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 31-922, 31-924, 31-927, 31-928.

§ 31-927. *Application for payments—Time for filing—Contents.*

The Commissioner may from time to time set dates by which applications for payments by the Commissioner under section 31-926 for any fiscal year must be filed. A payment under section 31-926 by the Commissioner may be made only if the application therefor—

- (1) is approved by the Commissioner upon his determination that the applicant meets the eligibility conditions of this subchapter; and
- (2) contains such information as the Commissioner and the Secretary may require to make determinations required under this subchapter and such assurances as they may find necessary to carry out the purpose of this subchapter.

Jan. 5, 1971, Pub. L. 91-650, title III, § 308, 84 Stat.

§ 31-928. *Method of making payments under § 31-926.*

Payments under section 31-926 by the Commissioner may be paid in advance or by way of reimbursement at such intervals as the Commissioner may find necessary and with appropriate adjustments on account of overpayments or underpayments previously made. (Jan. 5, 1971, Pub. L. 91-650, title III, § 309, 84 Stat. 1935.)

§ 31-929. *Definitions.*

For purposes of this subchapter:

- (1) The term "full-time students" means students pursuing a full-time course of study in an accredited school of medicine or school of dentistry leading to a degree of doctor of medicine, doctor of dentistry, or an equivalent degree.
- (2) The terms "school of medicine" and "school of dentistry" means a school in the District of Columbia which provides training leading, respectively, to a degree of doctor of medicine and doctor of dentistry, or an equivalent degree, and which is accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education of the United States.
- (3) The term "nonprofit" as applied to a school of medicine or a school of dentistry means one which is owned and operated by one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(Jan. 5, 1971, Pub. L. 91-650, title III, § 310, 84 Stat. 1935.)

Mr. MAZZOLI: Under the wording of this legislation, it would appear that the private, nonprofit, accredited schools of medicine and

dentistry at Howard University also would qualify for the assistance proposed. I have been informed, however, by President James E. Cheek of Howard University that it is not the present intention of his school to participate in this program in view of the special support which Howard now receives from the Department of Health, Education, and Welfare.

Nevertheless, Dr. Cheek in his letter to me stresses that like Georgetown and George Washington, the colleges of medicine and dentistry at Howard University are both in need of financial assistance.

At this point, without objection, I would like to make as part of the record our letter from Dr. Cheek.

[The letter referred to follows:]

HOWARD UNIVERSITY,
Washington, D.C., January 22, 1974.

HON. ROMANO L. MAZZOLI,
House of Representatives,
Committee on the District of Columbia,
Washington, D.C.

MY DEAR CONGRESSMAN MAZZOLI: In reply to your letter of January 16, 1974, please be advised that circumstances have not changed at Howard University. However, it should be clear that the Colleges of Medicine and Dentistry at Howard University are both in need of financial assistance, and we would hope that the legislation as drafted by your Committee will continue substantially in its previous form.

Thank you for the opportunity to respond to this matter.

Cordially,

JAMES E. CHEEK, President.

HOWARD UNIVERSITY,
Washington, D.C., March 16, 1970.

DR. SEYMOUR ALPERT,
Vice President for Development, The George Washington University, Washington, D.C.

DEAR DOCTOR ALPERT: This is to acknowledge your letter of February 27, 1970. Howard University understands fully that which George Washington and Georgetown Universities are striving to accomplish. However, because of our relationship to the Department of Health, Education, and Welfare, we cannot participate in your proposal.

Please be assured, however, that you have my personal support in your endeavor and I sincerely hope that it bears fruit.

Sincerely,

CARLTON P. ALEXIS, M.D.,
Vice President for Health Affairs.

SCOPE OF HEARING

Mr. MAZZOLI. I believe all of us here today are very much aware of how valuable the local medical and dental schools are to this community. Through the operation of university hospitals and clinics, and through the provision of residents and interns who can fill house staff positions at other hospitals, these institutions contribute greatly to the overall delivery of high quality health care in the metropolitan Washington area. In addition, the presence of centers of teaching medicine in this community affords opportunities for continuing education or refresher courses to sharpen and update the skills of doctors and dentists in local practice.

Thus, the fact that representatives of two of the community's three medical centers appear before us today to plead financial distress is of great concern to me and to the Congress and to our country.

In considering the legislation before us today, we will address several broad questions: How did these institutions come to fall into their present fiscal condition? From personal experience with the medical and dental schools in my own home district of Louisville, Ky., that was just taken into the State system of higher education, I am aware that there is a national pattern of hardship in this area. Perhaps a national, rather than a local solution should be explored.

Second, since we are being approached as the equivalent of a State legislature which might provide State aid, we need to explore whether such aid should be appropriated through the District of Columbia budgetary process. Under this bill, the subsidies would be funded by the Department of HEW under its overall budget, and with home rule in the offing within less than a year, in my judgment, we must recognize that there soon will be an elected legislative body in this community which perhaps should more properly consider the question of State aid.

Third, we need to examine the roles of these institutions whose enrollments are more national in character than local in meeting the educational and medical manpower needs of the District of Columbia. I have been informed that less than 10 percent of the graduates of these schools have remained in the District to practice, and that only about 25 percent have remained in this area of Maryland, Virginia, and the District area. Present enrollment in these schools I am told is well over 90 percent from jurisdictions other than the District of Columbia.

Finally, I think we must explore the fact that no funds ever were appropriated under this authority during the 2 fiscal years, fiscal years 1971 and 1972, that the law was on the statute books.

We also should explore the Federal financing pattern for these schools for 1973 and 1974, during which this legislation has lapsed. We must seek to determine whether the Secretary of HEW would seek funds in future years under this authorization, were it to be renewed by this Congress.

Before commencing this morning's testimony, I would like to acknowledge the receipt of written testimony in support of this legislation and order that it be included in the hearing record; such statements in support of the adoption of H.R. 11108 have been received from Hon. Paul G. Rogers, our colleague from Florida, Hon. Walter E. Fauntroy, our colleague from the District of Columbia, William M. Bucher, executive vice president and director, Hospital Council of the National Capital Area, Inc., the American Dental Association, and the American Association of Dental Schools; Minnie Bowick Edwards, vice president of the Central Northeast Civic Association of the District of Columbia; and Henry J. Johnson, Jr., president, Rogers Meomrial Hospital chaplain's staff, president of the Capital Hill group ministry.

The American Medical Association, I am informed, has also filed a statement in support of adoption of this legislation.

Without objection, these statements will be made a part of the record.

Mr. MAZZOLI. At this point I would like to yield to my good friend from the adjacent State of Maryland, Congressman Gude, who has some remarks.

STATEMENT OF HON. GILBERT GUDE

Mr. GUDE. Thank you, Mr. Chairman.

As you know, the medical schools at George Washington and Georgetown Universities and the dental school at Georgetown have long served this area and indeed the entire country. The graduates number over 10,000 doctors serving communities in every State.

Further, their location in this particular metropolitan area has provided these schools with unique opportunities to contribute to the national health scene through their affiliation with Federal institutions nearby, such as Walter Reed and the National Institutes of Health. The Armed Forces Medical School will soon be underway in Bethesda. I am sure these schools will serve as a resource for this new health manpower program.

The financial need of these schools is well documented and known to this committee for years past. Since the formula in this bill provides for funds of up to \$5,000 per medical student, and \$3,000 per dental student, as proven to the Secretary of HEW, I believe there is an adequate review mechanism to show proof of need.

I also note that similar programs in the States for complementary support from State legislatures for the private medical schools average about \$5,500 per student. In light of this Nation's critical shortage of doctors and the continuing rise of the cost of higher education, particularly in the medical fields, I believe it is essential to continue the Medical and Dental Manpower Act for the District.

I urge that we give this legislation a favorable report.

Mr. Chairman, as you well pointed out, we do sit as a State legislature for the District of Columbia, and though home rule is down the road within a year or so, we need this legislation to fill a gap until the City Council of the District of Columbia is able to address this matter as do the State legislatures across the country which provide comparable support to medical schools in their States.

Thank you, Mr. Chairman.

Mr. MAZZOLI. Thank you very much, Mr. Gude. I appreciate your statement.

Is Congressman Broyhill here at this point,

For the moment, then, let us go on to the next witness.

Congressman Broyhill has a written statement in support of the legislation and will be here to read it.

The first group would be a panel from the Department of HEW, constituting Dr. John S. Zapp, Deputy Assistant Secretary for Legislation and Health; Kenneth M. Endicott, Administrator, Health Resources Administration; and John C. Greene, Director, Bureau of Health Resources Development, Health Resources Administration.

Gentlemen, if you would arrange yourselves as you wish around the table. I understand Dr. Zapp will be the principal witness.

STATEMENT OF JOHN S. ZAPP, D.D.S., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION AND HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY KENNETH M. ENDICOTT, M.D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, AND JOHN C. GREENE, D.M.D., DIRECTOR, BUREAU OF HEALTH RESOURCES DEVELOPMENT, HEALTH RESOURCES ADMINISTRATION

Dr. ZAPP. Good morning, Mr. Chairman and members of the subcommittee. We appreciate this opportunity of appearing before you to testify on H.R. 11108, a bill to extend for 3 years the District of Columbia Medical and Dental Manpower Act of 1970.

DISTRICT OF COLUMBIA MEDICAL AND DENTAL MANPOWER ACT

The District of Columbia Medical and Dental Manpower Act of 1970, which was enacted as title III of the District of Columbia Revenue Act of 1970, authorized the Secretary of Health, Education, and Welfare to make grants to the Commissioner of the District of Columbia for private nonprofit medical and dental schools in the District.

The act authorized grants in amounts the Secretary determined to be the minimum amounts necessary to carry out the purposes of the act, but in no event to exceed, in the case of a medical school, \$5,000 times the number of full-time medical students, or, in the case of a dental school, \$3,000 times the number of full-time dental students enrolled. In determining the amounts of grants, the Secretary was required to take into consideration any grants to the respective District of Columbia schools under the health professions educational assistance authorities of title VII of the Public Health Service Act relating to financial assistance to health professions schools in serious financial distress.

The District of Columbia Medical and Dental Manpower Act of 1970 expired June 30, 1972. The bill that you are considering today, H.R. 11108, would extend it for 3 years, and would authorize the appropriation of such sums as are necessary for carrying out its purposes. It would authorize the Secretary of HEW to assist private nonprofit medical and dental schools in the District of Columbia in a manner similar to that in which certain States support private medical and dental schools located in their respective jurisdictions.

Mr. Chairman, if you will recall, the Department of HEW has testified on similar legislation in the past, in fact, as recently as April 1972. At that hearing the administration recommended strongly against enactment of legislation similar to the current bill. Nothing, Mr. Chairman, has happened in the interval to warrant the passage of this legislation. Our position remains essentially the same today as it was in 1972.

STATE LEGISLATION

We believe this committee should note that not all States support private medical or dental schools in their respective jurisdictions. Of the 22 States having 50 private medical schools, 9 States provide no financial assistance to 14 such schools. Of the 14 States having 22 private dental schools, 8 States provide no financial aid to 13 of these schools. Even in those States that do provide assistance to private medical and dental schools, the amount of support provided varies widely, and the purposes for which the assistance can be used are limited. When a State does decide to support a private medical school, the State usually considers specific benefits which might accrue from such support. State considerations usually involve the need for adequate numbers of trained health professionals for health care, research and training; the need to expand educational opportunities for residents of the State; the need for new knowledge, and the need to develop new methods of providing health care to groups as well as to individuals.

For example, California contracts with its private medical schools to expand the class sizes of these private schools. Delaware contracts with an out-of-State college of medicine to accept Delaware residents with a stipulation that a portion of the medical students spend their clinical clerkships in the Wilmington Medical Center. Ohio has a contract medical program which requires that the private university supported must agree to admit a specified number of medical students. New York has three types of contractual arrangements with each private school in the State: (a) A plan which provides an award for each medical school graduate; (b) a per capita award for every medical student enrolled; and (c) a 7-year plan designed to increase enrollment during the period from 1967 to 1974. Illinois provides funds to private institutions within that State to increase enrollments in medical, dental, nursing, and allied health education programs. Each private school in Illinois receives an award for each Illinois student that school enrolls with the requirement that a specified number of residents be enrolled above the average number for an earlier year. In addition, an annual stabilization grant is made to each school computed on the average number of State residents enrolled. A single non-recurring expansion grant was also made by Illinois, but even this award was contingent upon the private school's commitment to increasing enrollment.

PENDING LEGISLATION

In contrast to the limitations and conditions regarding State support for private medical and dental schools which obtain in the above-cited cases, H.R. 11108 would authorize grants to be made to the private District of Columbia schools without reference to any benefits that might accrue to District residents. In this additional respect, therefore, the legislation would depart from the approaches to support of private health professions schools followed in most of the States.

It is certainly the case that private schools draw their students from a wider area than do State-supported schools and to that extent serve the needs of students from other States. For example, for the 1971 to 1972 academic year George Washington Medical School has 128 first-year students, of whom only 11 were residents of the District of

Columbia. Equally significant, the Georgetown University School of Medicine accepted 216 first-year students, of whom only 11 were residents of the District of Columbia. Similarly, the Georgetown School of Dentistry accepted 138 first-year students during the 1972-73 academic year and only 5 were residents of the District. Thus, for three first-year classes totaling 482, only 28, or 5.5 percent were actually District residents.

HEW RECOMMENDATION

The critical equity issue that constantly arises with respect to proposals to support private District of Columbia medical and dental schools out of Department of Health, Education, and Welfare appropriations is whether there are overriding reasons of public policy to justify singling out, from the entire universe of private medical and dental schools in the United States, the schools in the District of Columbia for preferential funding treatment from the general revenues of the Nation. We feel that there are no such reasons. It is therefore difficult for the Department of Health, Education, and Welfare to rationalize selecting out three medical and dental schools in the United States for special treatment solely on the basis of their location within the District of Columbia.

Mr. Chairman, the issue which this legislation presents is basically identical to the issue that confronted the Congress in December 1971, when the House of Representatives voted down legislation, H.R. 11628, 92d Congress, to perpetuate a program of special subsidies to hospitals in the District of Columbia, over and above the benefits they received under the Hill-Burton construction assistance program. In floor debate the opponents of that legislation effectively highlighted the inequities to other States and localities arising from continued provision of general tax resources to District of Columbia facilities in a manner and in amounts disproportionate to those available to other jurisdictions. We believe that the arguments that were successfully advanced against that earlier legislation apply with equal force to consideration of H.R. 11108.

PRESENT PROGRAMS

I think it is important to note that to date the Department has not found it necessary to provide special funds to these schools under the District of Columbia Medical and Dental Manpower Act, but instead has provided basic assistance under the generally applicable provisions of the Comprehensive Health Manpower Training Act of 1971. The capitation grants awarded under that act have provided increased funds to schools of medicine and dentistry, several times greater than they received under previous formula authorities, and have improved fiscal stability in such schools. In fiscal year 1973, for example, Georgetown University Medical School received capitation grant assistance of \$1,447,563 as compared with \$259,500 under the old program in 1971; George Washington University Medical School, \$1,047,290 as compared with \$238,000 in 1971; and Georgetown University Dental School, \$859,571 as compared with \$223,000 in 1971.

The capitation grant program has contributed significantly to alleviating the financial distress of schools of medicine and dentistry. It

is still the case, however, that a number of schools temporarily needed yet additional financial assistance before they could carry out the steps necessary to solve their problems. In recognition of this fact, the Congress, in the Comprehensive Health Manpower Training Act of 1971, included special separate authority, in amounts which declined over 3 fiscal years, for grants to schools of medicine and dentistry, as well as other schools of the health profession, which are in serious financial distress, to meet their costs of operation or to meet accreditation requirements.

The act's financial distress authority was designed to provide financial assistance while at the same time identifying the factors that have led to financial difficulties and determining the appropriate means for remedying them. With this objective in mind, financial distress grants are made on special terms and conditions, including requirements that the schools agree to: disclose financial information or data deemed by the Secretary to be necessary to determine the source or causes of their financial distress; conduct a comprehensive cost analysis study in cooperation with the Secretary; and carry out appropriate operational and financial reforms on the basis of information obtained in the course of the study or on the basis of other relevant information.

In fiscal year 1973, the Department's Bureau of Health Resources Development awarded approximately \$7.8 million in financial distress grants to medical and dental schools in this country. Of this amount, approximately \$1.4 million was awarded to Georgetown University Medical School; \$583,000 was awarded to Georgetown University Dental School; and almost \$1.3 million to George Washington University Medical School. In other words, Georgetown and George Washington University Medical Schools received nearly half of all the financial distress awards to medical schools in this country, and Georgetown University Dental School received slightly over one-quarter of all such aid to dental schools. If one were to add to these amounts the dollars these schools also received under capitation awards and special project grants, the dollars awarded in fiscal year 1973 would total approximately \$2.5 million for George Washington University and almost \$5.9 million for Georgetown University.

PLIGHT OF DISTRICT OF COLUMBIA MEDICAL AND DENTAL SCHOOLS

The Department is of the view that, in general, the prolonged period of financial uncertainty experienced by these schools, the end of which is not yet in sight, reflects a serious deficiency in the administration of these institutions. For instance, the schools have not followed the common practice in other medical schools of instituting a viable intramural faculty practice plan to assure that some reasonable portion of the financial resources generated by certain of the clinical departments is applied toward keeping the other departments of the school on a sound financial footing. George Washington Medical School has given some thought to trying to reform its policies in this regard, and may be in a position to stabilize its finances in the not too distant future. The Georgetown schools, however, have thus far not moved to implement long overdue management reform to an extent that would correct their financial difficulties.

FEDERAL PROGRAMS

The effectiveness of the Comprehensive Health Manpower Assistance Act of 1971 is being closely studied at this moment inasmuch as the development of a sound and comprehensive manpower strategy is one of the highest priorities in our Department. The administration's recommendations on the health manpower authorities, which are scheduled to expire on June 20, 1974, will soon be sent to the Congress. The need for continued special Federal financial assistance to the relatively small number of health professions schools still experiencing financial distress, and the terms and conditions under which such aid should be provided, are questions that must be addressed by the Congress in that legislation. We believe it would be inequitable and inappropriate for the Congress to legislate preferential treatment for the private schools in the District of Columbia, without reference to the policies that will apply to the other schools in the United States similarly situated.

HEW RECOMMENDATIONS

In summary, we believe there is not sufficient justification for special preferential Federal legislation of the kind under consideration today, to assist these particular schools of medicine and dentistry. If public support is to be provided to these District of Columbia private schools, as it is provided by some States to private schools within their jurisdictions, we would respectfully suggest that this be provided by the District of Columbia government which in this situation occupies a role analogous to that of a State government. The District government is in a position to judge whether the schools' asserted need for such support makes a compelling demand upon the city's limited financial resources.

If financial distress assistance is to continue to be provided by the Federal Government to health professions schools, it is particularly important as a matter of national health policy that schools of medicine or dentistry receiving such aid should uniformly be required to meet the terms and conditions imposed by the provisions of the health professions educational assistance authorities. These provisions should be applied nationally to all schools of medicine or dentistry who find themselves in such a plight.

Therefore, Mr. Chairman, the administration recommends strongly against enactment of H.R. 11108.

Thank you, Mr. Chairman. I will be happy to respond to any questions you or the members of your committee might wish to raise.

Mr. MAZZOLI. Dr. Zapp, thank you for a very frank and forthright statement, and one that does cite the objections of the Department as to the adoption of this legislation.

To state the case, it seems that you feel to adopt this kind of bill would be a preference, an unwise preference at this time with respect to these schools in the District of Columbia, and it is the Department's position that we ought to continue with distress funding if it is necessary, under the health manpower.

Is that basically correct?

Dr. ZAPP. I think we have two points. That is basically one. The other is, if the District government and yourselves as their State legislature, so to speak, at this time, feel that they should have special

assistance, it should be carried out like it is in other jurisdictions, that is, through the District's authority, not through a national authority.

Mr. MAZZOLI. Let me ask you this, then. As far as point one of your two points, that the funding could be under the financial distress side, is there any assurance that you can give on behalf of the Department or on behalf of your organization that there will be money forthcoming at a time when it is needed?

FINANCIAL DISTRESS FUNDS

If I understand what I read in the paper correctly, HEW threatened and in fact, took steps to cut off financial distress funds last year, the spring of last year, until there were certain pressures brought to bear, I guess. Then the money was released.

Is there any assurance that you will give us that the schools here, if they prove financial distress, will not be thwarted in their receipt of the money?

Dr. ZAPP. Mr. Chairman, I could not certainly give you or the schools the assurance that they would receive the money in the amount that they are requesting. This is a national authority. There are a variety of schools in the country that have similar situations. We think it is a matter of national health policy that we would have to treat them equitably. I would also say that there are financial distress funds available in fiscal 1974. It would be up to the review council in this fiscal year to award that appropriately across the board.

There is also, as you realize, a supplemental appropriation for an additional \$5 million for which there is not an authorization yet to expend the funds, but the supplemental appropriation has been signed by the President.

Mr. MAZZOLI. Dr. Zapp, is there any application pending now from George Washington University, under this title, fiscal distress for fiscal 1974?

Dr. ZAPP. Yes.

Dr. ENDICOTT. There are applications totaling about \$31 million from eligible schools in the United States. The limitation in the act provides a ceiling appropriation of \$10 million, which has been appropriated in a supplemental bill which has passed and an additional \$5 million was provided, but the legislation authorizing the increase of the ceiling has passed in the Senate but has not been agreed to in conference. So the authorizing legislation is still pending.

This would bring to a total of \$15 million available and to meet the demands of some \$31 million in requests.

Mr. MAZZOLI. You have twice as many requests as you have possible money to supply the recourse.

Dr. ENDICOTT. Yes, sir. This is about par for the course. In previous years the review committees generally have pared down the requests substantially.

Mr. MAZZOLI. Dr. Zapp, you said you could give no real assurance that requests in subsequent years on the part of these two schools for financial distress funds would be approved by the Department.

Is that because you are not satisfied that they have taken your advice as to remedial steps at some point to lift them out of this financial distress, or is it because that you cannot now envision the basis on which

the distress funds would be applied for, or is it some other factor that causes you to say that you cannot give assurance?

PRESENT CONSIDERATIONS

Dr. ZAPP. There is a combination of factors: One, that the current legislation for health manpower expires at the end of this fiscal year. The administration has not yet submitted its legislation for its extension, nor have either of the committees which have jurisdiction. So I think from that standpoint no one can give any assurances of what will be in there.

I think history perhaps speaks well of what may be enacted. It does not fall in the assurance category.

The other point is the one Dr. Endicott raised. This year we will have approximately \$15 million, at such time that the increased authorization level is approved, and we have about \$31 million worth of requests in the Department at this time, so you can never promise any-one dollar for dollar.

The third part is Congress itself is going to have to decide on the basis of national health policy, in future years, what the Federal Government's role in support of all the health professions are and to what degree they will give the different institutions a commitment over a long-range period of time for what types of support.

It was particularly significant, Mr. Chairman, when the Health Manpower Training Act of 1971 and the Nurse Training Act of 1971 were enacted, that they brought into play essentially a different level and type of support. That is why my statement contains such a dramatic difference between the support received in fiscal 1971 and what they received in fiscal 1973. They went basically from a small formula in a lot of special projects that went inequitably to schools all over the country, to recognition that there should be some basic support that the schools should receive.

For that reason, the capitation awards were increased significantly. At the same time they made a very conscious decision that over a 3-year period of time, because the financial distress, the derby, as it has been called at times, was more prevalent than it is today, that this amount should decrease so the schools know on a long-range basis that the Federal Government cannot continually come in and bail them out. There is going to be a large amount for capitation available. There will be other types of target money available to them for special projects and so on, but whatever the reforms are—and they differ in each institution—they are going to have to undertake those reforms to see that they get on a stable basis, unless the respective State is willing to give them additional support.

What we have found from looking at the applications of the last 3 years, is that the schools that have been receiving concurrent financial distress awards from year to year, they have gradually decreased. In other words, they have been making attempts, apparently successful, in reducing the deficit that exists in the institution. There are a variety of ways in which they could have done it. The fact of the matter is that the request for financial distress indicates that they have done it in some manner.

What we have done in the District of Columbia private schools that are under consideration today, they have actually stayed stable or increased, and it has bucked the national trend. That is the reason we had a very generic statement within my statement, that we think that there must be some reforms within those institutions, and I am not here to say that it should be a faculty-student ratio or what have you. The national trend has gone the other way.

Mr. MAZZOLI. Dr. Zapp, the things that you are saying today and the sentences that you included in your statement are certainly profound and serious matters, and I think should be bolstered for the benefit of this committee and for the full committee with respect to what precisely these schools may not be doing which in the opinion of the Department they ought to be doing, and in what fashion. If I recall your statement, it was management steps or standards or something of that nature. To what extent have they been derelict in your judgment in adopting these management techniques, and ultimately, then, if these judgments and recommendations were to be implemented, what then would be the condition?

It is important for us to know. I am not a doctor. I am not in medical manpower. I really do not fully understand management techniques as they would apply to health services. Of course, we are going to have a lot of education on our own part because we are going to be facing this year and the next Congress some important steps in the Federal Government in health delivery. So it would educate us for the purpose of this bill and also for the future. Maybe you can supplement at some point, supply us with some further material which will be made a matter of this record with respect to what areas there might be some deficiencies in your judgment.

[The material referred to follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., February 22, 1974.

HON. ROMANO L. MAZZOLI,
Chairman, Subcommittee on Labor, Social Services and the International Community of the Committee on the District of Columbia, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: During our meeting with representatives of George Washington University and Georgetown University on February 7, 1974, you requested more specific data resulting from our review of the financial distress applications made by these schools. I think you will find the enclosed statement responsive to that request.

The statement was originally prepared for delivery at our February 7 meeting. The statement was not read since as the meeting evolved I felt that an informal exchange was more appropriate. However, I feel that the points made in the introductory portion of the statement are worth making and tend to place our substantive comments regarding the administration of these schools in a clearer context.

I am also enclosing three additional documents which you asked for. The first is a copy of the AAMC summary of State roles in the financing of medical education, including data on State aid to private institutions. Additionally, the last two documents are copies of the official letters sent to George Washington University and Georgetown University notifying them of action taken on their fiscal year 1973 financial distress applications.

We appreciate the opportunities you have given us to present our position on H.R. 11108. If I can be of any further assistance, do not hesitate to call me.

Sincerely yours,

JOHN S. ZAPP, D.D.S.,
Deputy Assistant Secretary for Legislation (Health).

Enclosures.

STATEMENT REQUESTED BY REPRESENTATIVE MAZZOLI REGARDING THE ADMINISTRATION OF PRIVATE MEDICAL AND DENTAL SCHOOLS IN THE DISTRICT OF COLUMBIA

In the course of presenting testimony before the subcommittee of Labor, Social Services and International Community Committee of District of Columbia regarding H.R. 11108 reference was made by the DHEW representatives to deficiencies of the administration of the institutions in question. Specifically, it was stated that, "The Department is of the view that, in general, the prolonged period of financial uncertainty experienced by these schools . . . the end of which is not yet in sight . . . reflects a serious deficiency in the administration of these institutions. For instance, the schools have not followed the common practice in other medical schools of instituting a viable intramural faculty practice plan to assure that some reasonable portion of the financial resources generated by certain of the clinical departments is applied toward keeping the other departments of the school on a sound financial footing. George Washington Medical School has given some thought to trying to reform its policies in this regard and may be in a position to stabilize its finances in the not too distant future. The Georgetown schools, however, have thus far not moved to implement long overdue management reforms to an extent that would correct their financial difficulties."

Subsequent to this, it is our understanding that officers of the two universities stated to the committee that they are not aware of any alleged deficiencies or of any changes suggested by your department (DHEW) which have gone unheeded. A spokesman for George Washington University said his medical center had pioneered in the development of a plan for pooling faculty fees."

On this basis the committee chairman Hon. Romano Mazzoli invited representatives of DHEW and the institutions in question to his office for a discussion and expressed the expectation that documentation of any deficiencies in management or administration be made available. We welcome the opportunity to discuss these matters in a constructive spirit and to this end are providing additional background material pertinent to some of the aspects of our concern.

In the first instance, we recognize that the statement as quoted from our testimony (cf. above) may appear unduly harsh, judgmental and simplistic since it was not accompanied by adequate explanation and dealt with a most complicated and difficult matter.

It should be understood by the committee and the institutions that our concern has a *realistic basis*. These institutions have applied for financial assistance because of need every year since 1968. During the last three (3) years this application was made under the financial distress program. During these three years the applications have been intensively reviewed by expert consultants drawn almost exclusively from experienced medical center administrators and financial management personnel of such institutions. In two (2) of these years the applications received additional evaluation by special review committees whose membership was largely drawn from the rolls of professional school administrators and academicians. Lastly the Advisory Council on Health Professions Education has reviewed and acted on the applications. *Every year*, at *all levels* and by virtually *all outside consultants criticism and concern* have been voiced about various aspects of their operation. The outside expert consultants have usually recommended disapproval or expressed uncertainty because of confusion in the data supplied. The review committees recommended disapproval in two of the prior years. (There is no review committee this year because of a change in the system occasioned by increased regional office participation.) Last year (1973), the advisory council actually disapproved the applications in toto on the first action. Later they reversed this action after special reconsideration. They finally recommended funding at a reduced level.

The criticisms and concerns have varied from year to year and from institution to institution. In the earlier years of the financial distress program DHEW had great difficulty obtaining data which was internally consistent and understandable. Sometimes studies initiated or designed by outside groups such as the AAMC cost study generated data which appeared inconsistent with the financial statements submitted by the school. The administrators were responsive to this frustrating situation. Dr. McNulty of Georgetown University and Dr. Feffer of George Washington are to be commended for a significant improvement in the data supplied to DHEW. Despite these improvements there always remain areas requiring clarification. The precise details of the faculty practice arrangements at Georgetown University is one such area.

It is our purpose at this point to present highlights of the principal criticisms and concerns, school by school, for the current round of application review. It should be borne in mind that reviewers have looked at the applications from the standpoint of the financial distress legislation. This includes the view that it was the intent of Congress to eliminate financial distress over a three (3) year period and enjoined all of the applicants to present such a plan.

GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

The following are excerpts from the reports of consultants and staff reviewers: "This application reflects little progress in improving practices which have concerned reviewers in the past two years. Among these are (1) Continuance of the apparently arbitrary 60-40 percent allocation of costs in the basic science departments to the medical and dental schools (2) Lack of information regarding the schools clinical practice plan. (3) No indication of considerations of actions to reduce costs when necessary through reduction or elimination of program or activities and other actions to contain or reduce costs, (4) continued program expansion, in some cases substantial (5) continuance by the school of the contentions that in the absence of federal support the University Board of Directors will have to consider relinquishing control of the school with no satisfactory explanation of what this means, and (6) treatment of unapplied gifts as assets rather than income."

Two reviewers commented on the substantial percentage increase in the Department of Community Medicine and International Health, the Department of Biophysics-Physiology, and the Dean's Office as indicating continued program expansion. "Faculty salary expenses are slated for a 12% increase while the number of students increased only 7.5%." One reviewer commented as follows: "My observations would indicate the lack of any substantial effort to increase the income from endowment and investment or gifts while at the same time making little effort to control salary increases or staffing." The same reviewer asks "Why there is so little increase in sponsored programs and Faculty Medicine Services?" "Why is there no allocation of University surpluses to this condition of distress."

In summary, concern has been clearly expressed by the reviewers because there is little evidence of effective cost containment and/or activities leading to expanding income. Some concluded that there is undue emphasis on additional federal funding as the only alternative. DHEW expresses disappointment that the administration of this school has not designed and/or implemented an effective plan during the last three years which would reduce costs and/or expand income such that balance in its operations is within sight.

GEORGETOWN UNIVERSITY SCHOOL OF DENTISTRY

The following are excerpts from reviewers of this application:

"Aside from certain specific information this application is the same as submitted by their sister school of Medicine . . . the majority of my comments made in the Medical School report are also applicable here. . . . Like the Medical School the applicant points to numerous increases over which they have little control. A number of these have been initiated by the University. . . . With financial distress support over the past years the University has not given any support and none is projected for this or future years. . . . Little is included in the application to indicate the School's consideration of alternate potential sources of income. . . . Their fund raising has not been good and they indicate very little commitment to improving their present . . . practice plan. . . . They have stopped efforts toward cost reduction because their Executive Faculty concluded that "further reductions would so adversely affect the quality of education that accreditation would be seriously threatened." Other reviewers echo comments about expanding the Dental Clinic income, more vigorous fund raising and some help from the parent university. There is reference by all reviewers that no plan has been presented to eliminate or substantially reduce the imbalance except obtaining additional federal assistance."

In summary, the reviewers were concerned by the lack of a plan which addressed itself to cost containment and/or expansion of income with particular reference to Dental Clinic income and fund raising.

The following are excerpts from reviewers:

"The record of funding of operating needs for this private D.C. Medical School totals \$5,297,600 over the 3-year period, and this year's application will require an additional \$2,782,210 for deficit, the largest request made by the institution under the program. In fact, the earlier projections of operating deficit made by the institution fall under the deficit projected now. In short, the institution goes nowhere in resolving this matter except in a circle of deeper difficulty. * * * The institution has realigned management, revised its budget and operating procedures to program oriented purposes, imposed ceilings on spending, position control, and instituted a wage and salary compensation program. The management effort is sincere and certainly one that is changing the life style in the institution. It is, nonetheless, to little avail in reversing the trend begun long before the distress fund mechanism. Last year the reviewers concluded that the applicant's actions were not as effective as might be expected, and the results were disappointing. The result this year is no better, in spite of additional management activities, ranging from reorganization with Center control, the tuition increase, to improved wage and salary management, and continuation of manpower freeze, to new funds for endowed chairs. In short, as management tightens its grip on areas of immediate concern, new problems arise with uncontrollable features to continue the high deficit trends. * * * The deficit is really programmatic in origin. Retrenchment must occur if the deficit is to be removed."

The view of another reviewer is as follows:

"Deficits projected through 1976-77 increase in total amounts each year but remain relatively static in terms of percentage of total expenses. The clear implication is an inability to curtail total expenditures in the face of huge expense increases. (20% of total). * * * Expenses as a result of expansion are substantial and continue to compound at a rate of roughly 20% a year. Faculty salaries will be up 18%; staff salaries, 11%; equipment will increase 7%; operation and maintenance of plant will increase by over 100%; and Medical Center and university services will increase 15%. One may seriously question the magnitude of these increases in light of the programmatic increase and a period of financial distresses. * * * In general, the increases are not unbelievable. *However, the increases do not speak to the issue of financial distress but rather to expansion despite financial distress.* * * * Plans to curtail expenses are modest. * * * One may be both critical and question the distribution of practice plan income which results in apparent positive balances in "Medical Center Appropriated and Unappropriated Funds." These balances were, according to the 1972-73 annual report of the university, \$1.6 million and \$2.9 million, respectively. The practice plan income is first applied as an offset to hospital losses. Balances remaining are transferred to the two funds mentioned before as well as an education and development and plant funds. The precise disposition of the fund balances derived from the professional practice plan is difficult to determine for the period in question. It is, however, evident that a substantial reserve exists which is operating as an endowment. These reserves have in the past and would presently be used to defray some of the current and projected deficits just as it has been used to defray the same short-falls in the hospital."

SCHOOLS IN FINANCIAL DISTRESS

DHEW has gained considerable experience with schools in financial distress since the implementation of this program. Many applicant schools were denied funds, some received reduced amounts and still others a full award. The actions taken by such schools have been impressive and include such drastic actions as terminating some existing faculty members, reducing faculty positions, reducing or eliminating faculty salary increases, gaining control of practice funds for general utilization, dipping into endowment funds, reducing or eliminating non-essential programs, putting community service programs on a self-sustaining basis, expanding alumni giving, deferring capital improvements and purchases, rescheduling educational programs to optimize faculty time, shifting costs to hospital budgets where appropriate, and seeking increased support of parent universities. In state schools it is usually not possible to budget a deficit. When legislatures do not expand support rapidly enough to offset loss of federal research and training funds or to offset increased costs it became mandatory to

bring income and expenditures into balance. Whatever the circumstances, it is always a painful process since schools—their administration and faculty—are reluctant to reduce the scope and richness of their programs. We understand and sympathize with the efforts at Georgetown University Schools of Medicine and Dentistry and George Washington School of Medicine to maintain the diversity and range of their programs, to retain and attract faculty, in short continue at the present levels of academic excellence. We also recognize that the administrations of these schools have taken some steps in the direction of effecting economies. Nonetheless, other schools have managed to effect very significant changes without obvious harm in their undergraduate medical educational programs.

There are other private schools without state aid and limited reserves or with markedly restricted assistance which have "made a go of it" during these days of rising costs and fluctuating federal support.

In closing, we have attempted to present the background for the statement of 'deficiencies in administration.' We have highlighted the concerns of reviewers and placed their comments in the broader context of financially distressed schools. Obviously, we cannot and should not specify the precise steps these schools should take to bring their costs and revenues into balance. However, some approaches have been suggested.

[From the Journal of Medical Education, October 1973]

STATE ASSISTANCE TO MEDICAL SCHOOLS—STATE ROLES IN FINANCING MEDICAL EDUCATION

State legislatures in fiscal 1972 provided a total of about \$334.2 million for the operation of medical schools, exclusive of funds to schools in development and to teaching hospitals. Of this total, \$303.2 million went to 63 public medical schools located in the states providing the funds; \$1 million was made available through regional compacts to public medical schools located outside the states providing the funds. Private medical schools received approximately \$30 million from state governments—\$29.4 million in direct payments and \$0.6 million through regional compacts. Additionally, public and private medical schools received approximately \$1.8 million from city and county governments.

The level of funding provided by each state is presented in Table 1. These figures exclude funds channeled through regional compacts. On a total funding basis, state appropriations ranged from a high of over \$36 million for New York to a low of \$765,000 for South Dakota. Table 1 also lists the state appropriation per capita and the state appropriation per \$1,000 of personal income. In fiscal 1972 there was considerable variation in state expenditures for medical school operations relative to population and personal income. Missouri spent 99 cents per capita while 11 states spent over \$2 per capita. One state, Arizona, spent \$3.57 per capita for medical school operations. Based upon the state appropriation per \$1,000 personal income, the figures ranged from a low of \$0.21 per \$1,000 personal income for Minnesota to a high of \$0.76 for Arizona. Ten states spent over 50 cents per \$1,000 personal income for medical school operations.

SUPPORT OF PRIVATE MEDICAL SCHOOLS

State legislatures have been limited by institutional and legislative prohibitions in awarding state funds to private institutions. In recent years, however, pressures to increase the supply of physicians have led a number of states to offer support to private medical schools. The following is a summary of fiscal 1973 state and District of Columbia programs for the support of private medical schools:

California—The state contracts with its private medical schools to expand class sizes. In fiscal 1973 it appropriated \$660,000 to provide for 55 additional students at a rate of \$12,000 per student. This award was not contingent on the residency of students.

District of Columbia—In fiscal years 1971 and 1972 awards were made to the private medical schools—Georgetown and George Washington—not under the special legislation authorizing such support but under the Department of Health, Education, and Welfare's special project grants program to alleviate financial distress. Similar awards were made for fiscal year 1973.

Delaware—The state contracts with an out-of-state college of medicine to accept up to 20 Delaware residents per year. A provision stipulates that a "por-

tion" of the medical students spend their clinical clerkships in the Wilmington Medical Center. The state of Delaware pays \$7,500 per student to the private medical school, with an arrangement that guarantees a minimum annual payment of \$120,000.

Florida—In 1952, Florida enacted legislation to provide support to the first accredited medical school in the state, which happened to be a private institution. Continuing legislation was passed to provide \$6,500 per Florida student for those completing their education in four years (or \$8,500 per Florida student for those completing their education in less than four years in fiscal 1973. Use of these funds is limited to operating purposes.

Illinois—In the spring of 1969, the Illinois General Assembly enacted the Health Services Education Grants Act providing funds to private institutions for increasing enrollments in medical, dental, nursing, and allied health education programs.

TABLE 1.—STATE APPROPRIATIONS FOR PUBLIC AND PRIVATE MEDICAL SCHOOLS¹

State	[Fiscal years]			
	1972 State appropriation (thousands of dollars)	1972 private school component of State appropriation (thousands of dollars)	1972 State appropriation per capita (dollars)	1972 State appropriation per \$1,000 personal income (dollars)
Alabama.....	6,086		1.77	0.52
Arizona.....	6,317		3.57	.76
Arkansas.....	2,395		1.25	.36
California.....	32,109		1.61	.31
Colorado.....	4,365		1.98	.42
Connecticut.....	4,085		1.35	.25
Florida.....	7,438	2,780	1.10	.25
Georgia.....	7,623		1.66	.42
Hawaii.....	1,070		1.39	.27
Illinois.....	13,656	3,539	1.23	.24
Indiana.....	10,187		1.96	.44
Iowa.....	8,057		2.86	.65
Kansas.....	4,864		2.16	.47
Kentucky.....	5,284		1.64	.45
Louisiana.....	4,293		1.18	.33
Maryland.....	5,386	800	1.37	.27
Michigan.....	20,283		2.29	.46
Minnesota.....	4,197	32	1.10	.21
Mississippi.....	3,348		1.51	.48
Missouri.....	4,622		0.99	.23
Nebraska.....	3,504		2.36	.53
New Jersey.....	12,526		1.75	.33
New Mexico.....	2,182		2.15	.56
New York.....	36,105	8,814	1.98	.37
North Carolina.....	8,632	477	1.70	.45
North Dakota.....	795		1.29	.34
Ohio.....	16,921	2,250	1.59	.35
Oklahoma.....	3,779		1.48	.38
Oregon.....	5,544		1.63	.59
Pennsylvania.....	20,822	6,765	1.77	.39
South Carolina.....	5,243		2.02	.57
South Dakota.....	765		1.15	.30
Tennessee.....	4,143		1.06	.28
Texas.....	30,556	2,083	2.73	.65
Utah.....	2,473		2.34	.59
Virginia.....	6,995		1.50	.35
Washington.....	7,028		2.06	.45
West Virginia.....	3,781		2.17	.59
Wisconsin.....	5,141		1.16	.27
Total.....	332,610	29,416		

¹ The data relate to funds directly by the State to fully operational medical schools located within the State and to State-related schools in Pennsylvania. They exclude funds provided to medical schools through regional compacts. Data are not available for direct State support provided to the medical schools located in Puerto Rico and Vermont. The 1972 State appropriations are derived from the 1972 Liaison Committee on Medical Education Annual Medical School Questionnaire. Data for Indiana and Kansas universities are based on estimates from the 1971 LCME questionnaire. Population data for the "State appropriation per capita" calculation are for 1970 and are taken from the "Statistical Abstract of the United States," 1972, 93d annual edition, p. 12. Personal income data for the calculations in the last column are based upon preliminary 1972 figures from the "Survey of Current Business," April 1973, vol. 1 53, No. 4, p. 17.

Each school is allowed \$6,000 annually for each additional Illinois resident which it enrolls, with the requirement that at least 20 additional Illinois resi-

dents be enrolled in each entering class over the average number of Illinois students enrolled per class for the years 1964 to 1967.

In addition, an annual stabilization grant of \$1,000 per student, based on the number of Illinois resident students enrolled in the year 1967, is to be awarded. This grant was contingent upon a commitment by the school to the minimum expansion of 20 Illinois resident students in fiscal 1968.

A single, nonrecurring program expansion grant was made for each of the private medical schools for planning and capital construction, attendant upon increasing this enrollment. No grants were given for any expansion of less than 20 Illinois resident students, and grants to schools that expanded beyond 20 additional students were based on the projected size of the additional increment. Fifty thousand dollars was awarded for each of the first additional 20 Illinois resident students. Beyond this initial grant for each additional Illinois resident, \$20,000 is awarded each year for each enrollee projected above the initial increment of 20 such students.

Maryland—The state's private medical school received \$800,000 per year on an emergency basis in fiscal 1972 and 1973.

Minnesota—Legislation was passed for the 1973 fiscal year awarding \$8,000 per Minnesota resident.

New York—The state university system has three types of contractual arrangements with each private medical school in the state—(a) the Bundy Plan, providing \$2,400 for each medical school graduate; (b) a per capita award of \$1,500 for every medical student enrolled; and (c) a seven year plan designed to increase enrollment during the period from 1967–68 through 1973–74. In the seven-year plan the average enrollment for each class of medical students enrolled from July 1961 through June 30, 1966, was computed as the base; \$6,000 is paid for each additional student enrolled over the base period average.

An individual student may be counted only once for all of these programs through his first three years. However, both the \$1,500 grant and the \$2,400 grant may be awarded in the fourth year.

North Carolina—This state's contract medical program with its private schools of medicine provides a per capita grant of \$3,000 for each North Carolina resident enrolled. Five hundred dollars of this \$3,000 per capita awarded is held in a special scholarship fund to provide financial assistance to deserving North Carolinians enrolled. The only restriction is that the sum must be utilized so as to be highly beneficial to the overall welfare of the state of North Carolina.

Ohio—This state has a contract medical program whereby the private university agreed to admit and maintain not less than 110 first-year students in fiscal 1972 and to admit 125 first-year students in fiscal 1973. A subsidy payment of \$4.5 million was paid to the university for the biennium 1971–73. The subsidy was not contingent upon the residency of the students.

Pennsylvania—The amount of the awards measured on a per capita basis for fiscal year 1972 were as follows: (a) \$7,465 per capita to three state-related schools and (b) \$4,400 per capita to four state-aided schools. There was no change for fiscal year 1973. These awards are not contingent upon the students' state of residency.

TABLE 2.—REGIONAL EDUCATION PROGRAMS IN MEDICINE, FISCAL 1973

Program	Participating States	Contracting institutions		Number of students		Total funds to—	
		Public	Private	In program	Per capita award	Public schools	Private schools
New England Board of Higher Education.	Maine, Massachusetts, and Rhode Island.	1	-----	159	\$5,000	\$720,000	-----
Southern Regional Educational Board.	Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Tennessee, and Virginia.	-----	1	110	3,250	-----	\$357,500
Western Interstate Commission for Higher Education.	Alaska, Arizona, Hawaii, Idaho, Montana, Nevada, and Wyoming.	13	3	246	3,000	656,000	82,000
Total	-----	-----	-----	515	-----	1,376,000	439,500

¹ \$2,500 each for 30 students who are Maine residents.

One of the major characteristics that differentiates "state-related" from "state-aided" schools is the university board of trustees. The state appoints a certain number of members to the board of trustees of a "state-related" university, thereby giving the state a direct hand in making policy decisions that govern the operations of the institution.

Rhode Island—The state's private medical school received a \$200,000 grant from the state for fiscal 1973, with no restrictions placed upon the use of the funds.

Tennessee—The state appropriated \$40,000 for support of its private medical schools for the 1973 fiscal year. This amount was divided between the state's private schools on a formula basis reflecting the increase in the number of Tennessee residents who enrolled in each school over an established base.

Texas—The Texas legislature appropriated close to \$2.1 million in fiscal 1972 for that state's private medical school. That figure has doubled to \$5 million for fiscal 1973. This represents a change of from \$14,370 per private student for fiscal 1972 to \$17,282 for fiscal year 1973.

Funds are channeled through a coordinating board which contracts directly with the private medical school. The support to the private medical school, during each scholastic year, equals the average annual state tax support per undergraduate medical student at the established public medical schools multiplied by the number of Texas undergraduate students at the private medical school.

Wisconsin—The state has appropriated funds on a biennial basis for medical education in its private medical school since 1969. The amount appropriated during the 1971-73 biennium was \$3.7 million. No restriction on the use of the award was made, nor was the grant contingent upon increased enrollment or the residency of an enrolled student.

REGIONAL CONTRACTS

The three regional boards—New England Board of Higher Education, Southern Regional Education Board, and the Western Interstate Commission for Higher Education—have a combined total of 18 contracts with accredited public and private institutions. Funds flowing through the boards for contract programs in medicine totaled nearly \$1.6 million for fiscal 1972. Nearly \$1.8 million was made available for fiscal 1973 (Table 2).

ROBERT CAROW,
AAMC Division of Operational Studies, Washington, D.C.

FEBRUARY 28, 1973.

DR. JAMES J. FEFFER,
*Associate Dean for Student and Curricular Affairs, The George Washington University School of Medicine,
Washington, D.C.*

DEAR DR. FEFFER: As requested in your telephone call of February 26, this letter provides an explanation of the action taken by the National Advisory Council on your financial distress grant request.

In recommending that the application be considered unacceptable, the Council appeared sympathetic to the unique circumstances surrounding D.C. schools and recognized the absence of state support. However, the Council was most concerned about the absence of an identifiable plan for reducing or eliminating fiscal deficits in future years, and could not identify definitive examples of significant internal actions (in the Council's opinion) taken to reduce annual deficits. Concern was also expressed about the circumstances which permit the medical school to incur deficits while practice income generated by salaried faculty is retained by the hospital. The Council also believed that there was no convincing evidence that failure to receive financial distress funds would cause the school to close, or to reduce the size of its medical class, or that the school's accreditation might be placed in jeopardy. For the above stated reasons the Council, therefore, concluded that the application did not adequately satisfy the guidelines for acceptability, or the intent of the financial distress legislation.

If you have any questions about the action, please feel free to contact us.

Sincerely yours,

HARRY W. BRUCE, Jr., D.D.S.,
Director, Division of Physician and Health Professions Education.

FEBRUARY 28, 1973.

DR. MATTHEW F. McNULTY,
*Vice President for Medical Center Affairs,
 Georgetown University,
 Washington, D.C.*

DEAR DR. McNULTY: As requested in your telephone call of February 27, this letter provides an explanation of the action taken by the National Advisory Council on your financial distress grant request.

In recommending that the application be considered unacceptable, the Council appeared sympathetic to the unique circumstances surrounding D.C. schools and recognized the absence of state support. However, the Council was most concerned about the absence of an identifiable plan for reducing or eliminating fiscal deficits in future years, and could not identify definitive examples of significant internal actions (in the Council's opinion) taken to reduce annual deficits. The Council also believed that there was no convincing evidence that failure to receive financial distress funds would cause the school to close, or to reduce the size of its medical class, or that the school's accreditation might be placed in jeopardy. For the above stated reasons the Council, therefore, concluded that the application did not adequately satisfy the guidelines for acceptability, or the intent of the financial distress legislation.

If you have any questions about the action, please feel free to contact us.
 Sincerely yours,

HARRY W. BRUCE, Jr., D.D.S.
Director, Division of Physician and Health Professions Education.

DISTRICT STUDENTS

Mr. MAZZOLI. Let me as you to comment on the fact you brought up in your statement, which I think is important, if you are looking at our role here as a State legislature; that would be to what extent the District of Columbia students are present in the school populations, and to what extent they are not present, whether or not this is any conscious effort to exclude the District of Columbia youngsters, or whether it is in fact a reflection of something else, whether or not the presence within this three-State area of the practitioners who have graduated from these two schools, there is a paucity of such practitioners in this area. Maybe you can give me some comments on that.

Statistics I have always been somewhat prejudiced against, as to say 5 percent do not practice here or 10 percent do. I think you have to put some meat and bones on it. Tell me, in your opinion why these are important facts, whether it should affect our judgment if we are in the role, at least in part, of a State assembly.

Dr. ZAPP. The reason these were included in the statement, Mr. Chairman, is so that we could get into a dialog on exactly this point. Why the admissions process does not admit more students from the District is perhaps a question that subsequent witnesses can answer better. Frankly, I do not think we are familiar with the admissions practices to know of how many District students apply and how many were accepted.

That would be relevant data, but I do not have it available. As it relates to support, particular support, I mentioned a number of different illustrations, and I think we could provide more for the record to help the subcommittee and the full committee in their analysis of the pending legislation, more examples of what other States have done when they have given special assistance to private nonprofit institutions within their jurisdictions. The illustrations I have used have shown that they have been generally directed toward the benefit of that particular jurisdiction, recognizing that generally private institutions

draw in more out-of-State students than do State institutions. But we see the case in Illinois, in New York, and other States. They are tending to try to move those schools in a point of saying, we realize you have some financial problems because you do not get State support. We are willing to give you State support. But the State has a manpower need. To do that you are going to have to help us meet our need.

Mr. MAZZOLI. Dr. Zapp, you really do not have with you the information to say that this lack of presence in the school population right now of young people from the District of Columbia is indeed the product of some effort on the part of the admissions people to keep students out or to show a lack of interest in the District student?

You really do not have information to show that it seems to be the fact that these practitioners who graduate go on to the other States from their origin or anything else is a lack of fulfillment of the role of admissions in these schools. That is what intrigues me.

If we have, in the case of Georgetown and George Washington, horses of a different color, then I think we ought to really understand it. If this is not like the University of Kentucky Medical School as it is to the State assembly of Kentucky, if we have a different relationship I think it is important to have that somehow put in the record, perhaps as a part of your supplemental material. You might try to hinge those factors together.

I am aware of the fact that most State assemblies would look at their State medical school as a product or as a producer of doctors who would practice within a State, and also the producers of doctors who come from within State. On that basis, they see the legitimacy of committing State funds for their education. It is a direct benefit to the State to do so. I do not see that situation here. I wonder why this would be the case for the District of Columbia to do this, if we are today at least sitting as a State assembly, because we are not getting a direct benefit from it. These youngsters do not practice in the District of Columbia, nor do they come from the District. So why should the District of Columbia in our role today make these commitments?

I understand the principle of what you are driving at. I wonder if we ought not to tie it up a little tighter.

With that, at this moment I yield to the gentleman, Congressman Gude, who may have some questions. I would like to mention also that Congressman Broyhill and Congressman Nelsen have also joined us. Congressman Broyhill, we will shortly hear from you.

DISTRICT PROBLEMS

Mr. GUDE. Dr. Zapp, in reference to the relationship of fees to the two medical institutions, and one dental institution in the District of Columbia, is HEW being critical of their services to the people as far as health care to indigents and similar services?

Dr. ZAPP. Certainly not to my knowledge, Congressman Gude. I do not think there was any reference in there. If any such thing exists within some part of the Department, I am unaware of it.

The issue is not the services that the university provides as a resource to the community. To my knowledge, they provide an excellent resource. There may be some areas that there may be a problem, but they are not ones that have come to my personal attention.

Mr. GUDE. Did your Department take this into consideration in looking at this legislation to the extent that these two institutions were providing a service to the District?

You state that their services are excellent as far as the citizens of the District are concerned?

Dr. ZAPP. Certainly we do, Mr. Gude. But this is something that we expect of all medical and dental schools across the country. There is nothing that separates out the District schools from those of any of the other private institutions on a national basis. This is a requirement of continuing accreditation. It is one of the more refreshing movements in health education today that most of them have become significant service components in the communities in which they reside.

I would also think, Mr. Gude, that since they are such a resource to the people, the District would tend more toward the District themselves making a decision on their own authorities, yourself, or later on home rule to some degree, that they would want to give additional support to them for that very reason.

Mr. GUDE. HEW would certainly be derelict in its responsibilities if, in preparing comments on this legislation you discovered that these institutions were not doing their job, and did not call our attention to that. This is certainly part of any examination of the quality of the institution, is it not?

Dr. ZAPP. I would certainly be very disappointed, Mr. Gude, if such a situation existed and it was not brought to my attention by the Department prior to my coming to the hearing.

Mr. GUDE. You suggest that under home rule that this is rightfully a responsibility of the District Council, and yet home rule is really a year away. Beyond that, the District government will take over some of the work that we perform here in Congress. I do not see any financial resources that the District government can fall on at this time, regardless of how the Commissioner and the District Council would feel about this.

Dr. ZAPP. My comment on that, Mr. Gude—on the first part, I did not mean the home rule at this point. I meant the Congress and this committee as a State legislature for the District now, and perhaps some form of home rule which would assume some of those responsibilities at a later date. As far as resources are concerned, we are really dealing here with public policy, not resource, and we are dealing on the same Federal treasury.

If so many hundred thousand dollars flow additionally to George Washington and Georgetown through the Federal Treasury as a matter of Federal expenditures as HEW authority rather than through District authority to me does not seem to be a matter of public policy. The matter of public policy to the Department is the fact that we have a responsibility for administering programs on a national basis, and it runs very counter to the type of programs that we operate to have a national program that has a particular earmark for certain institutions because of their geographic location and does not treat similar institutions in the same way because they happen to reside someplace else. If they are to be treated particularly, we would say, rather than having the money flow through a national authority, that it should flow throughout of the Federal Treasury through the authority that is directly responsible for the geographic location, which in this case is the District Committee.

Mr. GUDE. If a private medical school came to the Department and pleaded that it was in financial distress, it would naturally be incumbent upon HEW before giving financial distress funds to that medical school to examine its books and see if it had looked to all possible resources of funds.

Would this not be a manner in which you would proceed when an institution comes to you and pleads financial distress?

You do not just grant them funds on the basis that they are in financial distress without looking at their resources?

Dr. ZAPP. We certainly do not, Mr. Gude. A Department that has 87 percent of our funds on the uncontrollable side and 13 percent that could go through any discretion type of program, we certainly do not.

Mr. GUDE. Would you consider whether the institution had gone to the State legislature to ask them for funds, or would you ignore that as a possible source of money?

Dr. ZAPP. We would not ignore it. It would be something that would have to be taken under consideration. I am not sure, on a 1-year basis, we would rule out anybody because of the fact that they had not gone. But if it appeared that there was the opportunity to receive additional resources, and there was no attempt either to get those additional resources or to undergo financial change—in other words, lower their sights a little bit so they could live within available resources—then I think in subsequent years it would have to be a matter of consideration of support. That is why I cited the trend that I did earlier to the chairman, that what we have seen in other schools in financial distress, their awards and requests each year have gone down, the opposite from what we have seen in the District schools.

Mr. GUDE. If a medical school in the District of Columbia comes to you in financial distress within this year, knowing what you know about the structure and powers of the District government as they presently exist, you would not expect them to receive any financial assistance from the District government at this point; would you?

Dr. ZAPP. Mr. Gude, the experts sit here. You are the State assembly for the District. I would say the judgment is one for yourselves and for Congress. It is still a matter of a certain number of dollars flowing out of the Federal Treasury if approved for a purpose.

The question is, what is the proper authority to do that, if it is justified?

Who can best make that judgment?

We think the Federal Government should not get into that type of local special decisions beyond what we already have that is available for each of the schools upon a national competition basis.

Mr. GUDE. The Congress holds the purse strings for the District of Columbia, and the District of Columbia Council does not have any resources to call upon, except to come down here with hat in hand to ask us to help them.

Dr. ZAPP. That is the point that I was hoping to make. Maybe I did not articulate it properly, Mr. Gude. You are in a sense the purse strings for the District. If this committee feels that it is justified, knowing better than we do, that it be given financial consideration over and above what we administer, then we would say we have no objection to that. We do not feel a national authority should be on a categorical basis, that we should begin to separate certain schools

under a categorical basis as a matter of Federal policy and treat them differently from the balance of the schools.

DISTRICT OF COLUMBIA MEDICAL SCHOOLS

Mr. GUDE. You mentioned in your testimony, Dr. Zapp, and the chairman has referred to it, on the remark that you made on pages 8 and 9, that, "the schools have not followed the common practice of other medical schools of instituting a viable intramural faculty practice plan to assure that some reasonable portion of the financial resources generated by certain of the clinical departments applied toward keeping the other departments of the school on a sound financial footing." I think if there are some specifics here we should have them out on the table, so that the representatives of these institutions can answer this charge.

Can you give us some specifics?

Dr. ZAPP. I certainly will address this one, Mr. Gude, then I will return it to Drs. Endicott and Greene for more specifics.

The case here is that there is an intramural practice program arrangement in a lot of institutions in the program. In some cases they do not allow the funds that are generated by a particular department to flow out of that department into other departments that may be suffering financial problems. There are certain departments that are revenue-generating departments in some centers and certain departments that are not, that operate under a loss.

The point I was making here, one way to assist that is to allow the funds generated from one department to cover deficits in the other because you would actually accrue a surplus in one department and a deficit in the other. But if you do not use those surplus funds, you on paper show a deficit for those departments collectively. This is one of the management points, I understand, that was made. And the fact is, it is our understanding that George Washington University has given some thought of changing this policy in that regard. That is an example.

Mr. GUDE. Is that as specific as you can be as far as the departments are concerned?

Dr. ZAPP. Mr. Gude, I would like to turn to Dr. Endicott, who was previously the Administrator of the Bureau, and knows. He is the Administrator of HRA, and has been in charge of manpower programs during the course of the most recent authority that required certain class analysis procedures as a result of receiving financial distress awards. He will give us a little chronology.

Dr. ENDICOTT. Mr. Gude, in dealing with this generic problem with quite a large number of institutions, and to do it in an even-handed and reasonable way, one is confronted with a problem of trying to assign a dollar value to quality of education. This is where the disputes and the troubles are largely generated.

I think most of my colleagues in the area of medical education would agree that nearly any school in the country could operate for less if it were willing to make certain concessions with regard to quality. Quality is a very difficult thing to measure, as you know. The school which is striving for quality has to pay for it, and they have to pay for it in terms of faculty salaries, the number of faculty employed, and so on. There is an accrediting body that sets sort of minimum

standards. But this is by no means any absolute yardstick. It is a question of judgment.

When an institution slips, oftentimes in one or two departments, the accrediting body puts it on notice. If they do not improve those specific requirements their accreditation will be withdrawn. To do this they have to have a constant ebb and flow of quality judgments that baffles the accountant every time because he cannot get any absolute yardstick of quality.

In dealing with the two universities represented here and many others, I think it would be fair to say that there are some economies which could be achieved which have not been achieved. But these economies, if pressed hard, probably would have an adverse effect on the quality. And I am sure that these institutions would not want to operate medical schools which they thought were not excellent.

But, to get into a quality judgment here, which no one can absolutely resolve, while the statement here points out that some additional income could be generated by some changes in the internal administration with faculty practice, I think it would be a fair comment that that same charge could be leveled for a number of other State and private institutions across the country. It would be with the wisdom of Solomon to provide an absolute amount that should be supplied to each school.

I do not know if this is helping you any, but perhaps to explain the background by which we are operating in this area—I am hopeful, myself, as one with continuing responsibility for the Federal role in supporting medical education across the country that in this round of legislation on health manpower which will soon be coming up before Mr. Nelsen's committee that some consideration may be given to the generic problem of the private institution itself, because all of them are, to a greater or lesser extent, in the same boat. They do not have a dependable tax base, and they have a continual problem of trying to raise money from private charity, from State governments, when indeed one could look upon them all as a national resource of filling in the chinks, accepting students from States that do not have medical schools—and there are a number of schools that do not—or accepting students and providing doctors from States that do not have enough schools.

I think perhaps the difficulty that confronts this committee is that it is dealing with just a piece of the larger problem.

Mr. GUDE. In order to achieve some of the economies which HEW points out, I gather these schools would have to lower the quality of their instruction and the quality of several of the departments. I am just paraphrasing your words here.

Dr. ENDICOTT. This has been repeatedly pointed out to me by these institutions, and I think there is a good bit in their position. That position is not without merit.

Mr. GUDE. Are these schools not different in providing a higher level of care than many of the other private institutions that are listed on this sheet, which I believe was supplied by your Department? In many cases is there not a much more sophisticated level of medical care and these institutions have the ability to deal with more difficult cases?

Dr. ENDICOTT. I would not wish to accept the responsibility of making that kind of quality judgment about private medical schools.

Mr. GUDE. I was not indicating the quality of the care at other institutions, but merely for example, that these institutions may be better able to carry out more complicated procedures, such as open heart surgery, than a small private medical school in the country.

Dr. ENDICOTT. If we make comparisons I think we ought to compare the university hospital in general with a hospital that is not affiliated with a university. Here, without hesitation I would say that the university hospital is almost always equipped to provide more sophisticated treatment of difficult cases than one can find in a nonuniversity setting. And I would also state very freely without any reservation whatever that both of these universities do indeed provide a high quality of medical care, and they would rank well with other universities in this regard.

Mr. GUDE. Thank you very much.

Mr. MAZZOLI. Congressman Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman.

LEGISLATION REQUIRED

Dr. Zapp, I notice on page eight, as has been referred to in the past, moneys have been granted in the financial distress area to George Washington and Georgetown in the past. As I recall, we negotiated in that area before, and of the amount, the total amount, the amount that has been allocated has been quite a generous portion of the total. I am just wondering—the presentation that I have been faced with many times—here we have George Washington and Georgetown. We do not have a State to go to. Almost all of our medical schools will get capitation grants, what have you, from the Federal, at the same time they do have a State legislature to go to to supplement.

Now, it is possible that there may be some lack of wisdom in introducing a bill specifically to deal with it and not to go to the distress grant approach. But at the same time, is there really machinery here in the District of Columbia that will give the District of Columbia itself the facility to deal with a problem like this in the capacity that a State would have dealt with it?

This is the thing that bothers me some here.

Dr. ZAPP. Mr. Nelsen, I think on page 10 I made the statement that I felt that if the support were to be provided to these schools, first of all I think the history of support to the George Washington and Georgetown schools, what they have received from the Department and the national authority has been very favorable. Some private schools may make a case that it has been slightly disproportionate.

It would seem to me that this committee has the authority to pass authorizing legislation that the District Appropriations Committees could act on to give exactly this type of assistance to Georgetown and to George Washington if they felt that the needs merited it. We are not saying that we do not think that they have financial needs. We are saying that we do not think that our piece of national authority, which we worked out so long and arduously through the other committee that you are the ranking minority member on, should in a way become categorized for just two universities, and should remain national. If the

two schools truly need more than what is available to them through our health manpower training authority, then we would respectfully suggest that that should come through the District authorizations and appropriations acting as their State government, as has been the case in other States which decide to give their private institutions some additional support.

And the second question at that point for the committee would be whether they felt, Georgetown and George Washington, felt that they were such a national resource and so unique that they perhaps either would or would not want to put some considerations on those additional funds that we see some of the other State governments doing, such as so many local residents, increasing enrollment, something of that type. That would be a secondary decision after you decide that the District should give them financial assistance above and beyond what they are eligible for on a national basis of competition.

GRADUATES

Mr. NELSEN. What percentage of the graduates remain in the District, to sort of take that into account?

Dr. ZAPP. The figures that we have available indicate that the District of Columbia, Georgetown University School of Medicine, 11.2 percent; George Washington University School of Medicine, 14.7 percent. Those are the ones that are currently in practice.

Mr. NELSEN. The point that I was going to make is this, that if the schools are providing education to educate doctors and dentists and it is spread out through the country there then, would be, I think, a testified national responsibility, because those of us who serve on the committee know how short of health manpower we are.

I can easily see the point that you wish to make, that there is obviously a lack of resources and of facility to go to here that may not prevail in other areas. But is this the proper approach?

D.C. MEDICAL SCHOOLS

That seems to be perplexing us some. I would like to then pursue the next point that you make, the deficiency in the administration of the institutions involved.

Is it possible that in granting additional help as we have in the past, if we were to do it again, is it not possible that HEW and the schools could sit down and work out a plan that you require them to meet if the funds are to be advanced?

Are there some areas where we have overlooked some authority as far as HEW is concerned, in the event that money will be made available?

Dr. ZAPP. That is possible, Mr. Nelsen. We got some pertinent discussion from Dr. Endicott a while ago that anybody can cut their budget, but what happens to the quality of medical education in the process?

Having served 2½ years on the liaison committee on accreditation in the United States and Canada, I know quality of education is not that measurable. In that case, I was sitting with a committee of deans and other people who were experts in the field. Quality is difficult to measure.

But we are saying there are probably some reforms that could be implemented that would not lower the quality of care. If they would prefer to have certain excellences in the school that go above and beyond perhaps those in some other university then a means of paying for those has to be found, because we have found that as their financial distress increases have gone up the other schools we have been giving them to under the medical manpower authority have gone down. Something is different. They are bucking the trend.

FINANCIAL DISTRESS AWARDS

It could be a variety of reasons. My understanding is that their current proposal for financial distress is under review in the Philadelphia HEW Office because of our decentralization process, and that some of the things that would be suggested will be submitted to the committee for the record.

Mr. NELSEN. I am aware of certain requirements that are necessary as far as HEW setting up the sort of criteria. The University of Minnesota, for example, that have been hat in hand a bit on some parts, their application is not in order. They are being required to review it, which I think is right and fair, and the proper assumption of authority by HEW, and likewise in this case.

If we go the route of appropriating money and authorizing money, I would think the two schools would be perfectly willing and should be willing to sit down with you and review some of these things with the hope that maybe some of the standards or criteria that you may suggest be met.

To your knowledge, as to Georgetown and George Washington University, do they have any endowment, any foundation funds that come in?

Perhaps I should ask that of the witnesses themselves.

Dr. ZAPP. Personally, Mr. Nelsen, I would not be able to address that. Our records would have that. It would be available to submit it for the record. I would not want to create the false impression from our previous dialog that we do not think that they are attempting to make some reforms. As a matter of fact, it is our understanding that some of them that have been suggested as a result of financial distress awards that they have received in previous years, have been, in fact, made. We are saying that they are still bucking the national trend, and I agree with you that I think that if they continue to receive assistance under the authority that we have to operate on a national basis, these things should be reviewed annually. That was the intent, the specific mandate of the Congress in the Health Manpower Training Act.

That to me is one issue of the administration of the authority that we now have. A separate issue is, should that authority somehow be amended to give yet another consideration to them that the other schools in the country do not receive.

Dr. ENDICOTT. Mr. Nelsen, I might comment with regard to the general situation regarding endowment. The medical schools, the private medical schools in general, have been for some years eroding their endowment. They have had to do that in order to keep a flow. In other words, they have been spending their endowment for annual operating expenses or for construction of new facilities. So that in general, the private medical schools' financial positions have been deteriorating.

This was, I am sure, one of the considerations weighed by the Congress in 1971 when it for the first time enacted a general capitation for all schools. In arriving at a figure, at that time the Congress and the Department had no reliable data as to the cost, the actual cost of medical education, and an arbitrary decision was made with regard to this capitation. The capitation was provided equally to all schools.

This resulted in a situation in which there was sort of a windfall to those institutions which were in good financial condition, and it was not enough money clearly to meet the needs of the institutions which were in the worse financial condition, and by and large these were the private medical schools. Essentially, $2\frac{1}{2}$, 3 years later, the problem is back again and will have to be reexamined in the course of the next few months as to what we are going to do about it.

We do have a general problem in the United States of the private medical and dental and other health professional schools losing ground in order to maintain financial stability for a variety of reasons that are well known to this committee.

They are generally applied to higher institutions of learning across the country. Generally they are not doing as well as they were 10 or 15 years ago, the tax loss and so on.

Mr. NELSEN. The reason I asked the question, I know that some of our schools have an active program that graduates go out, some of them do well, and they cultivate an approach of trying to get supplemental assistance for the schools—it could be the University of Minnesota, the Mayo Foundation, they all have programs going.

I wonder if there is some lack of activity in that respect that could be cultivated? I want to further comment as far as spelling out as pointed out serious deficiencies. I do not think any one of us want to sit here and try to discredit the activity. I am sure that is true as far as you are concerned.

I think that if we can be helpful and you can be helpful, I am sure the disposition is there to do it and I have no further questions, Mr. Chairman.

Mr. MAZZOLI. Thank you very much, Mr. Nelsen.

Does counsel have any questions?

HOWARD UNIVERSITY

Mr. HOGAN. Is Howard University considered, Dr. Zapp, to be a national resource? In other words, is it unique?

Dr. ZAPP. It is unique in that it has been chartered by Congress and it does receive specific Federal assistance as a result of that. In that sense, it is quite different from Georgetown and George Washington.

Mr. HOGAN. It is almost total, is it not?

The financial assistance they receive is almost total?

Dr. ZAPP. Almost totally Federal?

Mr. HOGAN. Yes.

Dr. ZAPP. It is considerable.

The background and the type of support of the university having been established sometime in the 1860's or the 1870's.

Mr. HOGAN. Do you know how many graduates of Howard practice in the District of Columbia?

Dr. ZAPP. Yes, 16.8 percent.

Mr. HOGAN. Of their graduates?

Dr. ZAPP. I am talking about the medical school as compared to 14.7 for George Washington; 11.2 for Georgetown.

Mr. HOGAN. Those are all the medical schools that exist in the District of Columbia?

Dr. ZAPP. Correct.

Mr. HOGAN. Howard University is considered, then I gather, a national resource being unique in that respect, leaving the District of Columbia without any, what you would call, State institution at all?

Dr. ZAPP. I suppose that you could draw that conclusion, Mr. Hogan, yes. From the standpoint of assuming that the support that goes to them, goes to them because of the fact that they were chartered by Congress and therefore a national resource.

Mr. HOGAN. My point is that there is no State university. There is no State medical college, as such, in the District of Columbia.

Dr. ZAPP. Correct.

Mr. HOGAN. Would that tend toward subsidizing these colleges that exist here now making them unique?

Dr. ZAPP. The situation would be no more unique than other States that have private institutions within the political boundaries, which happens to be the case in the District of Columbia. They have several institutions within their political boundaries and they are all private. Of course, other States—it is like that in some cases, in some cases, it is a mix.

Mr. HOGAN. Delaware has no medical school at all within their boundary?

Dr. ZAPP. Yes.

Mr. HOGAN. They contract with other colleges—I am not sure which one it is—but your earlier statement indicated they contracted with another jurisdiction and they subsidize those students that go to those colleges?

Dr. ZAPP. Yes.

Mr. HOGAN. That is because they do not have any medical college of their own. Presumably if they had a medical college of their own it would be private or public, they would be subsidizing if they had a private college and their students went to the private college, they would be subsidizing those students I take it?

Dr. ZAPP. One would assume that the practice of Delaware and other States that have neither medical nor dental schools within their boundary, one would have to consider at that point on a theoretical basis, if Delaware were to do that and have an institution in their boundaries whether they would lay on some of the criteria for receiving that support, the criteria that many of the States have used before they would give funds to the private universities within their jurisdiction.

FINANCIAL DISTRESS AWARDS

Mr. HOGAN. You said distress has gone down in some of these other colleges. Do you know why they have gone down? Have they received more State aid? Or is it a more efficient and effective operation?

Dr. ZAPP. A combination of things.

One is the fact that the capitation authorization which became law at the same time as the decrease in financial distress put a sound financial base, or a sounder financial base I should say, under the universi-

ties across the board. I think that is one point that helped many of them out.

The other point is the frank recognition that financial distress awards from the Federal Government were going to be more and more difficult to get and the form of financing medical education is changing and they were going to have to look down the road, tightening their belts and being sure that they were able to live within the moneys that they had coming, either from State legislatures, endowments, or private funds, or special projects and so forth, that they were not going to be able to continually operate and go back in and get the same or larger amounts for financial distress year after year.

The Federal Government had said, as a part of national policy, we are going to decrease those awards, gradually. And I think it was a forecast to the universities in their planning process that they took it into consideration. In many cases, I am sure there was reform, just as we feel there has been some in George Washington and Georgetown.

Dr. ENDICOTT. May I make a comment here, sir?

One of the major causes of financial distress in medical schools has been the increase in cost of providing charity medical care. One has looked traditionally over the years to the medical schools to take care of the indigent population in the vicinity.

I think many of you are familiar with that. It is true of these schools. They make a major contribution to providing care to the indigent population of the District. The situation has been changing across the country with regard to meeting the costs of the care of the indigent.

One of the major elements in this was the enactment of medicaid in which the Federal Government provided matching money to the States for providing medical services to the indigent.

The States have acted in a very uneven way in taking advantage of the medicaid legislation. So, in some States the State puts up enough money, along with the Federal matching money. The school no longer finds itself to bear anywhere near as large a cost in taking care of the indigent; whereas in other political jurisdictions, for one reason or another, the State has not participated to a significant extent in the medicaid legislation.

That medical school, through no faults of its own, finds itself generating a major deficit through the care of the indigent. And there is really very little that the school itself can do to get out of this predicament except to turn away poor people, which generally speaking, is something that they do not wish to do.

In fact, some of them have told me they are afraid that the community would burn down the school if they closed their door to indigent patients. So they are caught in a real predicament, and perhaps the committee may wish to make inquiries of the representatives of the school as to the extent to which this poses a problem for these schools in this jurisdiction. Certainly in dealing with all of the schools, I have encountered this problem many times.

COSTS

Mr. HOGAN. One further question, Mr. Chairman.

If, as Congressman Nelsen was suggesting on this intramural not having intramural costs, if there are surpluses that are produced on

one area, I assume you are talking about total medical throughout the universities?

Dr. ZAPP. Yes.

Mr. HOGAN. If a provision were made for that, and if it were agreed that certain recommendations of HEW could be incorporated into any grants to these colleges, would you want that written into the law as Congressman Nelsen suggests so you would have that discretion?

Dr. ZAPP. I would tend to think that the statutory language that is currently in the Health Manpower Training Act of 1971 is probably about as specific as you want to get in that category.

As Dr. Endicott indicated earlier, changes in accounting practices, revenues that are generated by the hospital, the research grants that may come into the university or may be lost by the university, all these things change their financial picture from year to year.

I would believe that it would be very difficult to become specific in the types of reforms that any of the health centers would have to implement.

Mr. HOGAN. Thank you.

FINANCIAL DISTRESS

Mr. MAZZOLI. Dr. Zapp, does the administration intend to ask for a continuance of the Financial Distress Act, because you mentioned that this title would expire along with the major bill this coming summer?

Is it your judgment that the administration will ask for a continuation of financial distress?

Dr. ZAPP. I cannot give you an answer on that. There will be an extension. There will be a request of an extension of some kind of health manpower support authority. Whether within that at the time the administration submits a proposal it will have a specific financial distress organization, I am not in a position to articulate.

Mr. MAZZOLI. Do you think it ought to, or is that a question you are not comfortable with?

Dr. ZAPP. I feel very comfortable in answering it, in the sense that it depends on what the balance of the support is. There are a number of philosophies, Mr. Chairman, that have emerged in the support of health education, particularly in the last 4 years. Capitation was the major new change in 1971. There are other philosophies that are being, so to speak, floated between the committees and outside groups and within the Department.

It would depend as to which one was ultimate. If you have a very high capitation, or if you have a capitation of about the same level that you have now, which is significantly higher than it was a few years ago, there is still need for financial distress assistance to some schools as they begin to get themselves on board.

On the other hand, if you have a lower—or say, for an example, you just lower the mandatory increase that the House has insisted on as a qualification for being able to receive financial assistance, in many cases this renews the financial distress problem in the schools. If everything remains as it is today, there will be a need for some of the schools to begin to wind down and get on board, and in many cases it will be able to recapture more third party reimbursement.

But until that time comes about, there will be a need.

Mr. MAZZOLI. The reason I ask the question, of course, is pretty well self-evident. It puts us in a quandary here. If we are trying to tailor our approach to the long-run medical and medical-legal thinking, that is fine and dandy. But in the meantime, these schools may have existing needs that are not being fulfilled.

For instance, next summer you do not ask for a continuation for financial distress. In the meantime, perhaps some of us feel that this individual legislation may not be wise. But it is certainly imprudent not to have something for these two schools. It is a problem. And if you have any further information on that as to the administration's position as to the current state of the art with respect to financial distress sections in the new bill, I would be delighted to have that information. It would help in our judgment.

Dr. ZAPP. Mr. Chairman, depending on how long the hearing record is open, if it is open at such time that we transmit our health manpower legislation to Congress, it would be appropriate at that time to submit for the record how we feel this addresses this particular situation over the period of time that we are proposing an extension.

Mr. MAZZOLI. If we are caught between time constraints and philosophical impasses, what happens to these two schools between now and the future?

Assuming that they do not qualify for help from the District of Columbia, and if the Federal Government decides that financial distress is a short-term self-limiting kind of thing and that day is gone, and there is no financial distress section, capitation is decreased, we insist upon expanding enrollments, and the District of Columbia says, no, sir, we do not have the money, this is not a priority, what happens to these two schools in your judgment, based on the information that you have gathered about it and the management techniques and all the other things?

Where do these two schools go, and what condition will they be in?

Dr. ZAPP. There are as many negative variables put together there as possible. I do not think that particular sequence of situations could arise.

Mr. MAZZOLI. You do not think it could arise?

Dr. ZAPP. It is possible. In my judgment, I would not tend to think that it would arise. If that were the case, the school would have choices of dramatically raising the tuition, they would have choices of reducing certain expansion programs that they are involved in, they would have choices of changing their student-faculty ratio, I suppose. Probably a number of other things.

They would simply have to scale down the operation, as a business does, to the income that they have to support it. I am not saying that is good. I am not saying that would not hurt the quality of education.

Mr. MAZZOLI. That is what Dr. Endicott talked about, the quality of education and the health care delivery provided in the event that these occurrences might come together. That is what troubles me.

Dr. ENDICOTT. Mr. Chairman, I might offer a comment at this point with regard to time. The legislation under which we are now operating and now providing financial distress is essentially forward financed. That is, this year's appropriation is available to the schools for expenditure next year. So that the money has been appropriated, and we are still waiting on final action on authorizing legislation to provide

to \$15 million to cope with problems of financing distress of the schools; essentially, forward financing, however—and the capitation is provided on a forward basis.

However, in handling the financial distress, instead of anticipating financial distress we deal with it as it occurs, so that these schools will receive out of this year's appropriation capitation which they can spend next year, and they are in deficit or expecting to be in deficit during the current year and are applying for money which can be expended during the current year to meet their deficits.

HEALTH MANPOWER ACT

Now, the legislation, the basic Health Manpower Act, expires on June 30. This means that the year after next there is complete uncertainty as to what will be available in capitation, as well as what form, if any, the financial distress may take, so that the two universities are confronted with a current deficit, money appropriated—perhaps not enough, but money appropriated to cope with the current deficit, money also appropriated to provide capitation for next year, and complete uncertainty as to what the capitation, as to what the financial legislation will be next year.

We do not know, of course, when legislation will be passed with regard to health manpower. If you can base your judgments on past experience, the last time the legislation expired we went through nearly half of the year with no legislation at all on the books. It was enacted in November. If the health manpower legislation is not enacted by June 30 we will be in the same predicament, perhaps until Christmas of next year. So that is the general framework.

Mr. MAZZOLI. Thank you very much.

If there are no further questions, we would like to thank the panel for your very helpful testimony today, and we appreciate it.

I would like the record to show that we welcome our colleague on the full committee—not a member of our subcommittee, but one of the ranking Members of the Congress who has an interest in this legislation. I would like at this point to yield to my friend and colleague from the State of Virginia, Congressman Broyhill, who does have a statement with respect to the bill, H.R. 11108.

Congressman Broyhill.

STATEMENT OF HON. JOEL T. BROYHILL

Mr. BROYHILL. Thank you, Mr. Chairman, for permitting me to testify on this legislation, and permitting me to sit here with the subcommittee, giving me the opportunity to ask questions.

But, rather than ask questions of the witnesses, as you just said, I would like to rebut some of the statements they made. I have a prepared statement, Mr. Chairman. In order to conserve time, and for other witnesses to be able to testify, and to avoid some unnecessary repetition, I would like to submit it for the record.

Mr. MAZZOLI. Without objection, the entire statement will be made a matter of this record.

[The prepared statement of Hon. Joel T. Broyhill follows:]

STATEMENT OF HON. JOEL T. BROYHILL IN SUPPORT OF H.R. 11108

Mr. Chairman: I wish to express my strong support for the bill H.R. 11108, of which I am a co-sponsor, and which seeks to extend the D.C. Medical and Dental Manpower Act of 1970 for three additional years.

The 1970 Act (Title III of Public Law 91-650, approved January 5, 1971) was designed to assist the private nonprofit medical and dental schools in the District of Columbia, which are the Medical School of George Washington University and the Medical and Dental Schools of Georgetown University, in their critical financial needs in meeting the operational costs required to maintain their high quality medical and dental educational programs and to enable them to increase the number of students in those schools as a necessary health manpower service to the D.C. metropolitan area. To accomplish these purposes, the Act authorized the Secretary of Health, Education, and Welfare to make grants, through the Commissioner of the District of Columbia, to these medical and dental schools for fiscal years 1971 and 1972, in amounts not to exceed the sum of \$5,000 times the number of students enrolled in the medical schools of George Washington and Georgetown Universities and \$3,000 times the number of students enrolled in the Georgetown University school of dentistry.

The Act of 1970 also provided for the appropriation of Federal funds sufficient to meet the cost of these grants. However, these appropriations were never actually made, because the Department of Health, Education, and Welfare found enough money in their Financial Distress Fund for Medical and Dental Schools to meet this expense during the two years for which the grants were authorized. Also, sufficient funding from this same source has been granted to these schools for the two years since the expiration of this authorization, that is the two academic years ending in June of 1974, to meet this need to the present time.

However, the Universities have been advised that this source of funds will not be available to them for future years, and hence these schools now face the same dilemma which confronted them in 1970, as far as keeping in operation is concerned. For this reason, there is no question whatever of the urgent necessity of renewing the D.C. Medical and Dental Manpower Act of 1970 and authorizing the appropriation of Federal funds sufficient to meet the cost of these grants for an additional period of three years.

At present, there are 46 private medical schools in operation in the United States, including the two here in the District of Columbia. Of the 44 private medical schools located outside of the District, 41 are receiving support from the states in which they are located, and legislation is now in process in the two states in which the other 3 private medical schools are located which will afford these schools direct state support. Further, the average state support for these schools is in excess of \$5,000 per student, the figure which is sought for the two private medical schools in the District. State support for private dental schools throughout the country is also general, and exceeds on the average the \$3,000 per student which we seek for the school of dentistry at Georgetown University.

It is entirely proper that in the case of these local schools of medicine and dentistry, the Federal government act in the role filled by the state governments in regard to the other private medical and dental schools throughout the country. In the first place, these schools at George Washington and Georgetown Universities are actually Federal in nature and scope, rather than local. At present only slightly less than 6 percent of the total student body in these three schools are residents of the District of Columbia; and the total enrollment includes students from every one of the fifty states and the territory of Puerto Rico. Also, only 8 percent of the graduates of these schools presently in practice are so engaged in the District of Columbia; and again, these alumni are practicing medicine or dentistry in every state in this country and in Puerto Rico. Incidentally, I am appreciative of the fact that 110 students from my state of Virginia are presently enrolled in these schools, and that the health needs of Virginia are being met in considerable part by 729 practicing graduates of the medical and dental schools of George Washington and Georgetown Universities.

Thus, there is not a state in this country which does not benefit from the training offered by these fine schools, and in the aggregate to a degree far in excess of the benefit they provide to the District of Columbia, even though their contribution to the District is critically important to the Nation's capital also.

In view of these facts, there is every reason for this situation to be met and resolved by the Federal government rather than by the government of the District of Columbia.

While all higher education in the nation is presently confronted with grave financial difficulties because of the price-wage inflationary spiral which has been advancing at the rate of about six percent per year, the financial problems incident to medical education are particularly acute. This is because in recent years medical science has become increasingly complex, and the processes of diagnosis and therapy now encompass a vast array of technical services, powerful drugs, and increasingly complicated techniques. As these changes have added to the cost of medical care, so also have they added to the costs of medical education.

Also, medical education now embraces a wide range of responsibilities. Once confined to the limited work of educating the future doctor of medicine, the role of the medical school now encompasses major research programs, graduate education in both the basic and clinical sciences, and a growing responsibility for patient care and community service. As a result of this growth in responsibility, the medical schools have been asked to expand greatly their educational functions and to extend their services in the community health scene.

These trends have had their greatest impact upon the private medical schools, because of their crucial dependence upon operating income and endowment earnings. The repeated deficits which they have faced have forced them, in many instances, to use endowment capital to cover operating costs. This situation has given rise to substantial concern on the part of state governments for the private medical and dental schools within their boundaries, and the state support for such schools which I have referred to has followed.

Most of these state arrangements for support of private schools are in the form of a payment per student to cover annual operating costs of his education. In Florida, the legislature provides a payment of \$6,000 per Florida resident to the private medical school where he is studying. In Illinois also, the payment is \$6,000 per student, in Ohio it is \$5,100; and the state of Texas pays Baylor College of Medicine up to \$17,000 for each Texas medical student enrolled. All these grants are in addition, of course, to the Federal funds available to all non-profit medical schools including those in the District of Columbia.

The Georgetown and George Washington Universities have assumed an impressive and essential role in contributing to quality health care throughout the Washington metropolitan area. Georgetown University's faculty, house staff, and students are working in Arlington Hospital, Children's Hospital, the Hospital for Sick Children, and the D.C. General Hospital. In addition, Georgetown's specialty affiliation programs are located in the Washington Veterans Hospital, Providence, and Sibley Hospitals. The Georgetown University's School of Dentistry has similar involvements throughout the area.

The George Washington University School of Medicine also is making important contributions in the health professional area. This University, with its faculty, house staff, and students, has affiliation agreements with Columbia Hospital for Women, Fairfax Hospital, St. Elizabeth's Hospital, the Washington Hospital Center, Children's Hospital, and D.C. General Hospital.

George Washington has also extended its educational programs and specialty services into the Walter Reed Army Hospital, the Bethesda Naval Hospital, the Armed Forces Institute of Pathology, and the National Institutes of Health.

Both of these Universities have received excellent support from alumni and friends for capital funds. In addition, they have exercised heroic efforts to obtain operating financial support from private resources in order to remain in existence. Despite these efforts, however, the financial operating reserves for medical and dental education at both George Washington and Georgetown have become exhausted in paying for past years' deficits and both schools have had to use endowment funds for this purpose. Thus, these schools are faced with a widening gap between income and operating expenses, and when they came to the Congress in 1970 for Federal assistance they were in fact faced with the very real prospect of being obliged to close their doors.

The Congress responded to that critical situation by prompt enactment of Public Law 91-650, and the D.C. Medical and Dental Manpower Act contained therein was a very real life-saver for these fine schools, sustaining them through the present academic year. Now, however, that source of funding is expiring, and again grim necessity confronts these Universities.

H.R. 11108 will simply extend the provisions of the Act of 1970 through fiscal year 1977, which will assure the grants needed to keep these schools in operation

through that year. Meanwhile, I understand that the Department of Health, Education, and Welfare is seeking to come to grips with the financial problem facing all medical and dental schools throughout the country, in such a way as to implement a permanent program of financial assistance which will meet with the overall situation. If this goal is achieved, then further legislation applicable solely to benefits for the George Washington and Georgetown University schools of medicine and dentistry will not be needed.

Mr. Chairman, as I have pointed out, this is indeed a national problem, and not a local one, as the fact that more than 10,000 graduates of these three local schools are now practicing medicine and dentistry in every state in this union will attest. Regardless of any changes in the powers of the District of Columbia government or its scope of authority, the U.S. Congress will always be responsible for the Federal interest in this capital city. H.R. 11108 involves this Federal interest, and I urge the prompt approval of this proposed legislation.

Mr. BROYHILL. Of course, Mr. Chairman, I am supporting H.R. 11108, which extends the D.C. Medical and Dental Act of 1970 for another 3 years. I am a cosponsor, along with several other members of the subcommittee and the full committee, including the gentleman from Minnesota, Mr. Nelsen and my colleague from Maryland, Mr. Gude, and the chairman of the full committee. I am hopeful, Mr. Chairman, before these hearings are concluded we will have you as a sponsor, if not the sponsor of a clean bill.

As it has been pointed out, the legislation will provide for a grant of up to \$5,000 per medical student and \$3,000 per dental student attending the George Washington and Georgetown University Medical and Dental Schools. I did not hear all of Dr. Zapp's testimony. I tried to scan it as quickly as I could when I got here. But I think he confirmed the fact that we had not actually appropriated money under the old act or the existing act, but funds were appropriated under the so-called financial distress program, and as they stated, this program does terminate, and there may be some other program enacted, maybe by July or maybe sometime next year, and this leaves these schools in a rather serious uncertainty and places their operation in very serious financial jeopardy.

I was somewhat disappointed, Mr. Chairman, and rather surprised at the adamant attitude of opposition that was expressed by representatives of the administration concerning this legislation, particularly in light of the action that the Congress took yesterday on a proposal that was made by the administration. I do not want to say this being unkind to these previous witnesses, because they are here doing their job as they are supposed to do it, but I see this as inconsistent when the administration is trying to be generous and benevolent in helping other countries of the world get ahead. We have been doing that for many years to the tune of billions of dollars. And there were colleagues, as I recall, that took a position that rather than put out a billion and a half dollars to the other countries of the world, maybe we ought to take over some more of our responsibilities here at home, and especially since we are not raising much money as it is to meet those responsibilities.

What makes it even more inconsistent on the part of the administration is the fact that as recently as Monday afternoon the Secretary of HEW, Mr. Weinberger, appeared before an executive session of the Committee of Ways and Means, of which I am a member, and presented the administration's proposal for national health insurance programs. There is no question that we are going to have to do more in

that area, Mr. Chairman. It is absolutely ridiculous to even think in this age of modern civilization we would have any of our citizens that would have to suffer a lack of medical care because they do not have sufficient funds to provide it.

Whether the committee adopts the administration proposal or not, it will—possibly this Congress, but certainly within the next few months—we will adopt a national health insurance program so that no citizen of this country will have any call to suffer because of lack of financial resources. The proposal of the administration, the one that was enacted immediately, costs \$6.5 billion a year. That, along with the advent of medicare and medicaid, is placing increasing demands on medical services, and we are going to have to increase those services. We are going to have to increase the number physicians, as well as all other types of medical services.

So we are looking for ways of expanding these medical schools, rather than turn a deaf ear to the financial problems which they have that may cause them to have to cut back on some of their programs. My figures in my statement contradict somewhat the statements or the figures presented by the representatives of HEW insofar as the number of private schools and the amount of State help provided for the private schools throughout the country.

But I think that we could all agree that there are a substantial number of private schools in the country. I think the administration said there are 50. My figures shows 46. But certainly, some of the States have recognized the necessity of providing financial assistance to these private schools. The administration witnesses agree to that.

My information showed that one State provides as much as \$17,000 to a student in a private medical school. So I think you can agree that the State governments have acknowledged the fact that there is a financial responsibility to these private schools on the part of the State government.

This brings us to the key question here in this legislation. That is, What is the proper role for the Congress to play in trying to solve this problem? We have heard it said time and time again here this morning that the Congress sits here as a State legislature. That is true, Mr. Chairman. These colleges have no place else to go. The 48 other medical colleges, private medical colleges in the country, if they have financial problems they can at least go to their State legislature. What is the State legislature for these two medical colleges?

This Congress of the United States.

The representatives of HEW are here opposing Congress providing any additional assistance for these two schools that they do not provide for the other 48 private schools. If there were hearings held in the State legislature in the State of Virginia or any other State at this time for State funds to be provided to private medical schools, I am wondering if the representatives of HEW would be down there opposing the consideration of a proposal for State financing or State assistance for the financing of these medical schools. That is what we are doing here. This is not a raid on the Federal Treasury necessarily. They have no place else to go.

As I mentioned here about home rule, about the responsibility of the City Council, maybe the responsibility of this new government—Mr. Chairman, I do not think that we can stick our heads in the sand and shut our eyes and say that we have abdicated responsibility. I have

maintained, I have maintained since I have been in the Congress that we have a financial obligation and responsibility to the city that we cannot pass up.

In the home rule bill, as you recall, we provided for a Federal payment up to \$300 million per year to supplement whatever the new City Council can raise from its citizens. If that is not sufficient, Mr. Chairman, you know good and well we are going to have to come back here and legislate to increase that Federal payment.

We have said many a time on this committee—I know you, Mr. Chairman, agree with this—that the citizens of the District of Columbia, whether they tax themselves or we tax them, cannot be required to pay more than their counterparts in other States and cities in this country, because if they did it would be counterproductive. We would have the economy of that District of Columbia, the Nation's Capital, deteriorate. Once they tax all they are able to tax, or that we have levied a tax that we can afford to levy, we have to make up the difference, whether it be for medical colleges, whether it be for police protection, fire protection, welfare, streets, you name it. We cannot permit the services of this city to deteriorate. It is our responsibility. We cannot shut it out. We cannot delegate it to any other government or any other institution.

Something has been said here this morning about these medical colleges serving the Nation. You bet your life they serve the Nation, Mr. Chairman. Over 10,000 graduates serve every State in this Nation.

The question was raised as to the percentage of graduates that serve the Nation's Capital.

How about the physicians that serve the Nation's Capital who are graduates of other medical schools?

Are we going to shut off those physicians from coming in here, and shutting off the graduates from our medical schools going to other States?

SCOPE OF SERVICES

This has been going on for years. The hospitals in this area serve all the people of this country, the visitors, the Congressmen who are here who have been treated in all the hospitals here in Washington. These medical students, the faculty, the staff, service these hospitals, every hospital in the area. These schools are in metropolitan areas. These hospitals are metropolitan area hospitals. You will find it in any State in the Union. Go to Louisville. The hospitals there serve Metropolitan Louisville as well as the counties in Indiana. This goes back and forth. There is reciprocity involved. We cannot say we do not have a Federal obligation here, because other States benefit from it and not just the people of the District of Columbia.

We are the State legislature. There is no place else to go. We cannot permit the services of these universities to deteriorate.

Dr. Endicott mentioned the increased cost of these services. This has been going on for a number of years, 6 percent and up. Of course, in the medical school that is probably even more, as all of us are aware, we do not have to be physicians to know that medical science has become increasingly complex and its services much more vast. Therefore, that is even more of a problem, and part of the problem is the increase in cost.

This impact is even greater on the private schools because they are dependent upon operating income and endowments—Dr. Endicott again made reference to that, many schools are having to go into the capital funds of their endowments. Once they start doing that, they are on a collision course that means sooner or later they are going to have a problem whether we are going to close these schools or not. The problems these schools have had with inflation and increasing costs have forced these States to face up to the problem, as we have to face up to the problem to provide financial assistance, as I said a moment ago.

George Washington and Georgetown University Hospitals serve medical schools, serve every hospital here in the area, including the Washington Veterans Hospital, the Children's Hospital, the District of Columbia General Hospital, the Washington Hospital Center. And it is my understanding that Georgetown University Medical School has an educational program out at Bethesda Hospital, the National Institutes of Health, and Walter Reed.

So there is a national interest here. There are national services that are being provided that Congress should be interested in in addition to the role as a State legislature. These schools have received enthusiastic and generous support from their alumni and their friends. They have made an heroic effort to provide adequate operating funds, vast support for their operating expenses. They have been unable to provide sufficient funds. So they are now confronted with the prospect of having to close the door unless the Congress wakes up and does something about it.

We did respond in 1970, despite the opposition of HEW at that time. We have the same problem now. All this bill will do is extend it for 3 years. If HEW will come up with some program nationwide that can solve this problem, let them do so, but we cannot wait for another shoe to drop. We have a responsibility as a State legislature to pass this bill.

If they can come up with a nationwide program, we will not have to use this program. This is a national problem, Mr. Chairman, it is not a local problem. There are 10,000 graduates of these schools serving the Nation. This is still the Nation's Capital; there is no State government to turn to. There is no State government to pick up the tab; it is our responsibility, Mr. Chairman. I know we will face up to it.

I am hopeful that this committee will complete these hearings promptly and report the bill to the full committee. You certainly have my enthusiastic support, Mr. Chairman.

I thank you.

Mr. MAZZOLI. We appreciate your statement, Mr. Broyhill. It was well said, and it was a strong statement.

Mr. NELSEN. I think that I should have a little rebuttal time. I voted for that bill yesterday that you referred to.

Mr. BROYHILL. We have you on this one, do we not?

Mr. NELSEN. I would like to point out that the impression downtown, that they oppose assisting the schools is really quite unfair nor is it totally accurate. I think it is totally unfair to force George Washington University and Georgetown to come up here and go to a distressed area for funds. I think it is incumbent on the Congress of the United States, in view of the fact that there is no State to go to, that

somehow we should have by legislation some provision where these two schools could do what other schools do nationwide where they go to their State legislature and they make appropriations of millions and millions of dollars to the medical schools.

Yet we have nothing here in our legislative process other than to go to the distress fund area, which is, in my judgment, an incorrect image in this case, because there is no way they can operate other than being distressed, because you have no other place to go. So I do think Joel and I would be both in agreement that, maybe, legislatively we should put some kind of piece of machinery in the law so that each year the two schools that do a wonderful service, and I want to help them in every way I can—I have done so in the past, and I intend to do so at this time.

I just want to be sure that we do not leave an improper image. I think we all want to work it out. I am not about to criticize the school or HEW or anyone else. I think what we want are some answers, and I think we are going to get them.

Mr. MAZZOLI. Thank you very much, Mr. Nelsen.

Then next will be a panel of representatives from the District of Columbia government, Dr. Raymond L. Standard, Community Health and Hospital Administrator and Director of Public Health for the District, and William Robinson, Chief of the Legislation and Opinions Division, District of Columbia Corporation Counsel's Office.

Dr. Standard, welcome back, for 2 days out of the last 3 that we have been together, and Mr. Robinson, welcome.

However you want to arrange yourselves and however you want to approach it, Dr. Standard.

STATEMENT OF RAYMOND L. STANDARD, M.D., M.P.H., COMMUNITY HEALTH AND HOSPITAL ADMINISTRATOR AND DIRECTOR OF PUBLIC HEALTH, ACCOMPANIED BY WILLIAM ROBINSON, CHIEF OF THE LEGISLATION AND OPINIONS DIVISION, OFFICE OF CORPORATION COUNSEL

Dr. STANDARD. Thank you, Mr. Chairman.

I am certainly happy that there was a slight interim between Mr. Broyhill's very good presentation, certainly with all due respect to the presentation by Representative Nelsen.

I am here today representing the District of Columbia, and I would like to say that I am happy to represent the Mayor-Commissioner for the District of Columbia. I am Dr. Raymond L. Standard, Director of Public Health for the District of Columbia and Administrator for Community Health and Hospitals.

The District government has submitted a report on H.R. 11108, and identical bills, "To extend for 3 years the District of Columbia Medical and Dental Manpower Act of 1970." As stated in the Mayor's report to Chairman Diggs, since the bills would provide an extension of grant authority vested in the Department of Health, Education, and Welfare, the D.C. government defers to the views of the Secretary of the Department of Health, Education, and Welfare on the merits of these bills.

The D.C. government is aware of the continuing critical financial problems facing private medical and dental schools in the District

of Columbia. We recognize the need to find an effective, long-range means of providing adequate funding to alleviate this distress. We are in the process of considering additional assistance to meet the health manpower training needs of the District of Columbia.

PUBLIC HEALTH SERVICES ACT

We are reviewing what is done in the various States as well as the Federal Government program under the Public Health Service Act.

As this committee is probably aware, section 741(f) of the Public Health Service Act provides for the Secretary of the Department of Health, Education, and Welfare to repay a portion of an individual's educational loans incurred for the costs of education at a school of medicine, osteopathy, dentistry, veterinary medicine, pharmacy, optometry, or podiatry, when the individual enters into an agreement to practice his profession for a specified period in an area determined by the Secretary to have a shortage of and need for such health professionals.

NEEDS OF THE DISTRICT OF COLUMBIA

The District of Columbia is in need of professional health services. We would welcome the opportunity to work with the committee to develop a specific legislative proposal which would allow the District government to provide money in the form of loans and/or scholarships to students who are permanent residents of the District of Columbia for the purpose of attending a private medical or dental school in the District of Columbia upon an agreement by the student to practice in the District in a needy area for a specified number of years after graduation. The development of such legislation will require careful review by the city of the precise agreement and the extent to which resources will be available to the city to make such financial commitments. From a long-range point of view, however, the District government is convinced that such an arrangement, which provides financial assistance to students who agree to provide professional health services in the city, will be of great benefit to the city's residents who are in need of professional health services.

For the information of the committee, I have brought a copy of the U.S. Public Health Service handbook outlining the program under the Public Health Service Act for certain medical professionals who agree to practice in a shortage area.

Thank you for this opportunity to testify. I will be happy to try to answer your questions.

Mr. MAZZOLI. Thank you very much, Dr. Standard and Mr. Robinson.

Mr. ROBINSON. I have no additional statement, Mr. Chairman.

As Dr. Standard has indicated, the Mayor has submitted a report to the chairman of the committee. We would ask at this time that that be included in the record.

Mr. MAZZOLI. Without objection, it will be made part of the record.

[The report referred to follows:]

THE DISTRICT OF COLUMBIA,
Washington, D.C., January 24, 1974.

Hon. CHARLES C. DIGGS, Jr.,
Chairman, Committee on the District of Columbia, U.S. House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: The Government of the District of Columbia has for report H.R. 11108, H.R. 11186, H.R. 11207, and H.R. 11535, identical bills, "To extend for three years the District of Columbia Medical and Dental Manpower Act of 1970."

These bills would amend the District of Columbia Medical and Dental Manpower Act of 1970 (D.C. Code, sec. 31-922) to extend for three years the period for which appropriations are authorized to be made under the Act. The District of Columbia Medical and Dental Manpower Act of 1970, approved January 5, 1971, authorized the Secretary of Health, Education, and Welfare to make grants to the private medical and dental schools in the District of Columbia. The grants were authorized in the amount of \$5,000 per student for medical schools and \$3,000 per student for dental schools. The 1970 Act authorized appropriations of \$6,200,000 for fiscal year 1971 and \$6,750,000 for fiscal year 1972. The current bills would extend authorization to make such appropriations as may be necessary for fiscal years 1975, 1976, and 1977.

It should be noted that no appropriations were sought nor funds granted by the Department of Health, Education, and Welfare under the authority of the District of Columbia Medical and Dental Manpower Act of 1970, which expired June 30, 1972, to any of the qualifying schools—Georgetown University's medical and dental schools and George Washington's medical school. The Department of Health, Education, and Welfare, however, has provided funds to these schools through a number of other programs, including the Health Professions Educational Assistance authorities of the Public Health Service Act. These programs have included funds for construction purposes, grants for educational programs, student aid, and assistance with special projects.

H.R. 11108, H.R. 11186, H.R. 11207, and H.R. 11535 address themselves to a problem confronting local medical and dental schools, but one which is national in scope—the escalating costs of providing adequate education for a sufficient number of physicians and dentists to meet the nation's health care needs. In recognition of this need, the Congress enacted the Comprehensive Health Manpower Assistance Act of 1971 (Public Law 92-157) which has provided substantially increased Federal assistance to medical and dental schools on a national basis. The 1971 Act includes grants to medical and dental schools on a per capita student basis in a manner similar to that contained in the District of Columbia Medical and Dental Manpower Act of 1970. The Department of Health, Education, and Welfare indicates that under the 1971 Act the capitation grant program provided the following assistance in fiscal year 1973: \$1,447,563 to the Georgetown University medical school; \$859,571 to the Georgetown University dental school; and \$1,047,290 to the George Washington University medical school. These schools received additional "financial distress" assistance from the Department of Health, Education, and Welfare in fiscal year 1973 to meet their immediate financial needs.

In light of the foregoing representations and inasmuch as H.R. 11108, H.R. 11186, H.R. 11207, and H.R. 11535 would provide an extension of grant authority vested in the Department of Health, Education, and Welfare, the Commissioner of the District of Columbia defers to the views of the Secretary of Health, Education, and Welfare on the merit of these bills.

However, in recognition of the continuing critical financial problems facing private medical and dental schools in the District of Columbia and the need to find an effective, long-range means of providing adequate funding to alleviate this distress, the District Government is giving serious consideration to determining an appropriate method, comparable in scope and extent to that provided by many of the States, of furnishing additional assistance to meet the health manpower training needs of this jurisdiction. It is hoped that specific legislative proposals will soon be developed for consideration by the Congress.

The Office of Management and Budget has advised that, from the standpoint of the Administration's program, there is no objection to the submission of this report to the Congress.

Sincerely yours,

WALTER E. WASHINGTON,
Mayor-Commissioner.

Mr. MAZZOLI. Dr. Standard, that was a very interesting proposal and approach. As I understand it, it would be comparable to the Federal program for assigning doctors in the areas of need. This would be to generate students from the District, youngsters from the District, who would make an agreement, who will practice within the District in return for some forgiveness of loans for attending medical schools?

Dr. STANDARD. That is correct, sir.

Mr. MAZZOLI. It would certainly behoove the Congress, since we are looking for new ways to take care of health services and provide the care as well as in the area of teaching medical sciences, it would certainly behoove us to give serious thought to this kind of proposal. It might solve some parts of our problems.

Dr. Standard, are you at liberty to indicate whether or not this type of proposal has received some sort of benign attention downtown and would have certain favorable reactions from City Council and those in authority?

Dr. STANDARD. Which proposal are you talking about?

Mr. MAZZOLI. The one that you mentioned.

DISTRICT SERVICE AREAS

Dr. STANDARD. I think that it would be given some consideration by the City Council. If one would look at the distribution of physicians within the District of Columbia, you would see that at least six of our nine service areas do not have physician manpower to serve the needs of the individuals in that area. Over two-thirds of our physicians practice in service areas eight and nine, while the other service areas in the District of Columbia are deficient, particularly those areas in the inner city where the poor individuals live. So I certainly feel that it would be a proposal that could be accepted by the city government in terms of assisting us to find within our community our potential physicians that could attend the schools within the District of Columbia and, hopefully, provide manpower continuing into the future for our city.

Mr. MAZZOLI. Dr. Standard, what were the service areas, did you say eight or nine?

Dr. STANDARD. Nine has approximately 700 physicians practicing in that area. Service area eight has approximately 350.

Mr. MAZZOLI. Where would those service areas be geographically?

Dr. STANDARD. Geographically they are in the area around George Washington and the downtown area west of the park, where the areas east of the park, service areas three and four, Anacostia, are severely deficient in physicians. The far northeast and the near northeast also suffer more critically than the other areas, and six of our nine service areas are deficient by accepted standards in the number of physicians that serve the population.

I would like to cite that those are the areas where we have the highest indices, which shows that we need more health care for those individuals.

Mr. MAZZOLI. Dr. Standard, you and I walked in together this morning. So you were here for the testimony of the HEW representatives. As you know, as part of the questioning we got into the idea of our sitting here as the State assembly or the State legislature for the

District of Columbia. Those States that do provide supplemental assistance to private medical schools do so in part, at least, on the basis of trying to encourage young people from their States to go to medical school because there is certainly a need for health providers. They in turn practice their particular specialties in the areas of need so that there is some reason or some benefit that accrued to the States and that benefit was such that they could see their way clear to make capitation grants or other assistance.

A question that some of us had, is, is that situation analogous to our situation in the District of Columbia, in that these schools do not seem to draw their student population from the District, nor do the students that they produce, the doctors, reside here or practice here? So that is the question that was asked.

In your opinion—and it would be only that, because all of us have a certain judgment in these things—in your opinion, have these schools made a sufficient effort to get local students into the schools, and have they made a sufficient effort, or if not a sufficient effort, could the effort be improved insofar as producing doctors and dentists and medical technicians who would practice within the District of Columbia, particularly in those seven or eight service areas?

Dr. STANDARD. Let me say, sir, I do not know to the extent that their efforts have been in the past whether they have been great or very minute. I can only look at the statistics which were quoted here today in terms of actual results. I would say, however, that any program that should be approved should be a program that is at least going to have some benefit to District residents.

If you look at the number of people who are employed within our health care system and just look at the number of physicians. I had a tally made yesterday. I found, not to my surprise, but just to verify my belief, that over 40 percent of the physicians who work in the District of Columbia government health care system are foreign graduates. This means, then, that only a very few, by comparison, of American-trained physicians trained at the two local universities are a part of our health care system. I would like to verify that in numbers if I possibly can.

I do feel, therefore, if we are going to have any impact in time some stress and emphasis should be put on the local residents. Certainly, there is the ethnic and racial and cultural gap between foreign-born medical doctors and the population that they serve. They have provided an invaluable service, and I would like to say that at this time. Without their help we could not survive.

HOWARD UNIVERSITY

Mr. MAZZOLI. Doctor, let me ask you one final question and then I will yield to the other gentlemen.

There seems to be general agreement that Howard poses a special, unique situation in that it was chartered by the District of Columbia and, therefore, the HEW people felt that it was entirely appropriate that there be national legislation, that there be a Federal way to help financially in the university chartered by the Congress.

But HEW representatives felt that there was a different situation with respect to George Washington and Georgetown, partly because

they were not chartered by the Congress, but in part, too, because of the different character of the institution.

Now, in your judgment, do you agree that Howard should be given this type of special attention by way of a special law which gives particular relief, financial relief, as distinct between the other two schools that are here today that have the same kind of financial distress, but that do not seem to have this uniqueness of character, that there should be a special law on their behalf?

Dr. STANDARD. I cannot speak for Howard University in their absence today, not being involved in this request, speak for the fact that they are being rather heavily funded by the Federal Government and feel that they should not be involved in this situation. I think that any consideration that is given should have some strings tied to it that will assist the District of Columbia in taking care of its own health care needs. I feel that, although both universities are universities that are national in scope and perhaps international, I think certainly some consideration should be given to the District and its health needs.

I think the only way over time that we are going to have an increase in the health manpower in the other service areas is to devise a program that will speak to those needs.

Mr. MAZZOLI. Thank you very much, Dr. Standard.
Congressman Gude.

Mr. GUDE. Dr. Standard, I believe you alluded to the service that these two hospitals make to the District of Columbia. They do render a substantial service to the indigent population of the District.

Dr. STANDARD. Let me say, Mr. Gude, that all of the three medical schools render a valuable service. As was pointed out by one of the earlier panel members, we have shifted from a time and place where most of the health care for the indigent was provided free of charge to a point where now we have over 190,000 people enrolled in the medicaid program for which full reimbursement is made. We have less than 25,000 people who we would classify as medically indigent, so in terms of payment there is a greater availability of funds to pay for the services of those formerly considered medically indigent. Yes; they do provide a service. They are also covered under the medicaid programs, at least 80-plus percent of the population that we consider medically indigent.

Mr. GUDE. In your opinion, does medicaid cover all the costs of the service for a particular patient?

Dr. STANDARD. Medicaid covers usual and customary fees, sir.

Mr. GUDE. Does it cover this for every medicaid patient that goes to Georgetown or GW?

Dr. STANDARD. If they have a medicaid card, they usually pay the customary fees, the negotiated fee that is keeping with the costs, determinations made by the hospital and the staff who control the medicaid program.

Mr. GUDE. In no instance, then, is the hospital bearing any of the costs of the care of that patient?

Dr. STANDARD. Not for those patients that are enrolled in the medicaid program. This is now through the joint legislation, title 19, 50-percent matching from the District government, 50-percent matching from the Federal.

Mr. GUDE. Mr. Robinson, on the third page of Mayor Washington's letter, he recognizes the relationship of the District of Columbia to the hospitals being analogous to the private hospitals to their State governments. Is that not correct?

Mr. ROBINSON. That is correct, Mr. Gude. The Mayor, in his statement, in his report, does indicate that the District is giving consideration to the development of legislative proposals which would be comparable to those granted by the various States to various private medical and dental schools. As has been indicated, we would be glad to work with the committee in the development of those proposals, once they are in such a State to be transmitted. We will be glad to present them to the Congress for its consideration.

Mr. GUDE. In this coming year, would the District of Columbia be in a position to give support to the hospitals to the extent that they showed they were in financial distress?

Mr. ROBINSON. As I said, no specific legislative proposals are available at this time. But the intent of the Mayor's statement is to the effect that the District of Columbia will give consideration to a program of financial assistance to the private schools which is comparable to the various States.

Mr. GUDE. Thank you.

Mr. MAZZOLI. Thank you very much.

Congressman Nelsen.

Mr. NELSEN. One comment about Howard University. It is heavily financed; is that out of Federal funds?

Dr. STANDARD. When I say "heavily," I do not mean it is the totality. I think more than 50 percent of its funds, whatever that amount is, does come from the Federal Government.

Mr. NELSEN. The indigent load that is thrust upon these schools, is it possible that this is an area that we have overlooked from the Federal level and maybe should have assumed a little bit more in that respect with the medical schools? Is that a possibility?

Dr. STANDARD. There are less than 25 percent that we consider to be medically indigent, and the total responsibility of the State and does not qualify for the medicaid programs. This is what we are currently paying: \$38 a day for inpatient care, \$6 a day for outpatient care.

It was my recommendation in 1970, the first year I was health officer, that we increase that amount. That amount has not been increased today, but I think it is the general consensus of city government that a cost or a payment that would nearly approximate the actual cost should be a consideration given to those hospitals that take care of this category of patients.

Mr. NELSEN. The reference to getting the graduate to practice in the area is an interesting one. In our health manpower bill one of the problems that we have been confronted with constantly is to get a graduate doctor to move in as a general practitioner in the rural area, so we have provisions in the Health Manpower bill that would give a forgiveness if they do just that, practice in a rural area. Even then, we have not been too successful.

The only solution that we have been able to think up that helps is to have the young doctor, when he goes out there, marry the farmer's daughter—at least he stays in the rural area.

In this case, we are dealing with a city, not dealing with a rural area, or a city area; we are dealing with the District of Columbia. Is it possible, if we were to view this problem from the city point of view, of having a category of dollars allocated to a city so they in turn would have a little voice in the process? Maybe we are making the approach on a distress theory rather than a fundamental, long-range, durable kind of program looking toward the future which will give the city a little bit more of a voice in trying to do what you suggest.

It is certainly a justified goal, as far as I can determine. We would like to have the schools that we are helping here try to help the people that are here also.

I thank the gentleman for his statement. I have no further questions. Mr. MAZZOLI. Thank you very much, Congressman.

I would like the record to show that we have been joined, and we have the honor of welcoming to our committee hearing today a friend of mine from my own class, as a matter of fact, who is chairman of the Education Subcommittee of the Full Committee on the District of Columbia, a gentleman whose personal interests are very heavily involved in community services, particularly with community health care, as well as involved in the education in the District, and a gentleman who has an interest in this particular field which is before the committee.

With that, I would like to yield to the gentleman from California, my friend and classmate, Congressman Dellums, for anything that he wishes to say. And I think I speak for the committee, if you wish to ask questions or engage in colloquy, you certainly are welcome. Thank you.

Mr. DELLUMS. First of all, I would like to ask the chairman—and I am sure some of these matters have been dealt with prior to my coming.

First of all, with respect to distress funding, has HEW stated this morning whether they are or are not prepared to continue distress funding?

Mr. MAZZOLI. As the chairman remembers, as a matter of fact, the Chair specifically asked Dr. Zapp the question whether he, on behalf of the administration, could assure—and I used the word assurance—the continuation of distress funding. The doctor could not directly state that; he could not directly assure us, because of time problems and the fact that the health manpower program that will expire this summer has not been rewritten and the proposal is not yet on paper. He was unwilling and unable to make those assurances to me.

GEORGETOWN AND GEORGE WASHINGTON MEDICAL SCHOOLS

Mr. DELLUMS. Mr. Chairman, first of all, the location in the District of Columbia of Georgetown and George Washington medical schools it seems to me is a rather extremely important asset in the basic dividends that essentially are to be received by the District of Columbia. One, to provide medical and dental services for the citizens of the District; to provide training, teaching facilities for students from the District interested in medical and paramedical planning; and three, to provide doctors to serve the medical needs of the community.

From what I have been able to gather—and I guess I would like to address this question to the doctor—from what I have been able to

gather from a close look at these two training facilities would indicate that it leaves suspicion they are not living up to the above-cited commitments; namely, one, they are not heavily involved in providing medical services and facilities to residents here in the District; two, that they do not enroll and/or educate a significant number of students from the District; and three, that graduates of these schools tend not to remain in the District of Columbia.

I would like very much if you would respond as to whether or not these are reasonably accurate statements with respect to your perspective on these two institutions.

Dr. STANDARD. A lot of these things I will try to respond to. I think a lot of the factual information was given before. In terms of the actual numbers, it is my understanding in the last year's class of all three institutions, the total enrollment of District residents was only 5.5 percent, some 27 students out of over 500 or near 500. So the total number is 5.5 percent.

In terms of services that they provide, the institutions over the past have worked with the city and have been responsible for treating medically indigent patients at our city hospital, although, effective July 1, because of other commitments, I understand, one of the universities finds it necessary to move out of that situation, to move out of providing services in the institution. They both at the present time do have a prepayment program with the District of Columbia and a health maintenance demonstration program with the District government. The George Washington program services primarily, I think, service area 9. I could be corrected on that. The Georgetown program provides the prepayment program in the Edgewood Terrace area, which is near 4th and Rhode Island, Northeast. So those are their only commitments that I am aware of as it involves the community outreach.

I for one feel that community outreach is a very essential part of the delivery of health care in any community, and I feel that the reason that the District is so heavily involved with neighborhood centers is because there has not been a full commitment on the part of hospitals in its totality in the District of Columbia to become involved with the delivery of ambulatory health care at the local level.

You know, as we all know, that the cost of inpatient hospital care has become astronomical. The only way we are going to have any impact on decreasing the total cost of health care is through some way to provide either preventive health care, ambulatory health care, at the local level, to hopefully diminish the need for inpatient care and the high cost that goes along with it.

Mr. DELLUMS Thank you.

I have one other question.

AMENDMENT PROPOSED

If HEW is not prepared to state that they are willing to continue distress funding, obviously, then, opposing this bill would create some serious fiscal problems for the institutions involved. I would, then, like to ask whether you have any particular ideas with respect to how this bill might be modified in order to enhance the two institutions' commitments to the community; and, second, any ideas with respect to a method by which we may gain greater assurances with respect to fiscal accountability?

Dr. STANDARD. As health director of the District of Columbia, I have very selfish needs that the needs of the residents that I am responsible for are taken care of. I look at our health indices and I look at the lack of good health care facilities within the community, and I cry out almost daily to the institutions who provide health care in the institutions to reach out beyond their walls and provide services.

I think that any modification of the bill, or any modification that addresses itself to the District of Columbia and its needs, should look to how can these institutions within the District of Columbia be more responsive to the District in terms of the numbers of people that they train to work in those areas of greatest need, not just in the District of Columbia itself, but in the area where they are needed most. Those are the service areas where we have the highest number of medically indigent people, the highest number of people on medicaid, the highest health indices that speak of bad health care and lack of health care, at the same time we have the least number of health professionals providing services.

Mr. DELLUMS. Thank you very much.

I yield back the balance of my time.

Mr. MAZZOLI. Thank you very much, Congressman Dellums.

Dr. Standard, I have one question, as a layman, to perhaps clear me up on medical terms.

You said earlier that you did not believe that these two hospitals and schools were fulfilling, as well as they should, their role with respect to ambulatory health care or health centers.

To me, as a layman, am I to understand that this means like neighborhood health clinics, or do you mean a person can come in to an outpatient clinic on their premises? What precisely did you mean by this failure on their part?

NEEDS OF THE DISTRICT OF COLUMBIA

Dr. STANDARD. I look at this as the District as a whole.

This is not an indictment of these two hospitals, but this is an indictment of the hospitals on the whole, not only the District of Columbia, but elsewhere. Their primary goals or primary interests have been treating acute medical cases.

As a matter of fact they have not been heavily involved in preventive health care. They have not been heavily involved in providing care out in the community, in the neighborhoods where people who are most in need of health care live.

They do have the brown bench type of health care or clinics within their hospital walls which I do not feel add dignity to the level of care—it perhaps provides a quality level of care. It does not provide the dignity of care that I feel is needed by every individual who seeks health services.

I think he should be able to find resources within this community that are equivalent to the private resources that are available elsewhere. It is unfortunate that the physicians have vacated those areas of the city prior to the coming of Medicaid.

Now we find many frustrated individuals living in our inner cities who have a payment mechanism, but do not have facilities, decent facilities, where they can get high-quality health care.

I do feel that they are needed. This is not an indictment of these two institutions. It is an indictment of all hospitals that are involved in our urban health care delivery that have not seen fit to come outside of their walls to deliver care where it is most needed, and that is in the inner community.

Mr. MAZZOLI. Thank you very much.

Does counsel have any questions?

Mr. HOGAN. No.

Mr. MAZZOLI. Thank you very much, Dr. Standard and Mr. Robinson, you are very helpful to us today and we appreciate it.

The next group will be the panel that represents Georgetown University. That will be composed of the Reverend Robert J. Henle, Society of Jesus, president of the University; Mathew F. McNulty, Jr., executive vice president for Medical Center Affairs; Dr. John P. Utz, the dean of the School of Medicine; and Dr. Charles B. Murto, the dean of the School of Dentistry.

Gentlemen and fathers if you will arrange yourselves as you feel comfortable.

STATEMENT OF REV. ROBERT J. HENLE, S.J., PRESIDENT OF GEORGETOWN UNIVERSITY

Reverend HENLE. I am Robert J. Henle of the Society of Jesus, the president of Georgetown University. I have a brief statement on H.R. 11108, a bill to extend for 3 years the District of Columbia Medical and Dental Manpower Act of 1970.

Georgetown University is in a dilemma over the financial position of our medical and dental schools. The reputation of these schools is on a definite ascendancy as is evidenced by the nationwide volume of applications on the part of students and faculty.

We have substantially increased the student bodies of both schools as our contribution to the shortage of medical and dental manpower in the Nation as well as in the District of Columbia with its metropolitan area. There are over 10,000 physician graduates from the schools at George Washington University and Georgetown University in practice throughout the country, as shown on attached Exhibits.

FINANCIAL PLIGHT OF SCHOOLS

At the same time, despite our diligent efforts to raise moneys for the support of the operational costs of these schools, the Georgetown University Medical and Dental Schools had an operational deficit in the year 1972-73 of about \$3 million. The same range of deficit is occurring this present year.

Due to the enactment by Congress of the District of Columbia Medical and Dental Manpower Act of 1970, the Secretary of Health, Education, and Welfare met the deficits of the past years and we are in the process of applying for this year's deficit.

Medical and dental school education is the most expensive individual educational cost at our university. This is true of the medical and dental schools across the country.

We are making every effort to keep these costs in line and have been reasonably successful. The deans of our schools will show this in detail in the financial statements they present.

COMMUNITY INVOLVEMENT

Georgetown University's Medical Center is engaged in many medical service programs that are critical to the health care system of the metropolitan area. I point out specifically on the attached exhibit "Community Involvement by Georgetown University Schools of Medicine and Dentistry" the programs at our own hospital with its outpatient clinic, the P Street Clinic run by Georgetown and the program at the D.C. General Hospital with our essential medical manpower service to its departments of medicine and surgery. All of these area health services come from our having medical and dental schools.

[The exhibit referred to follows:]

THE CONTRIBUTIONS OF GEORGETOWN UNIVERSITY MEDICAL CENTER TO THE HEALTH AND WELFARE OF THE WASHINGTON METROPOLITAN COMMUNITY

There are several categories of programs through which the services, facilities, faculty and students of the Georgetown University Medical Center contribute significantly to the health and welfare of the community in the Washington metropolitan area. These include:

- A. Information to the Public
- B. Educational Opportunities
- C. Medical and Dental Services

A. INFORMATION TO THE PUBLIC

1. "Opinion Line" is broadcast over radio station WUST. Faculty members of the Schools of Medicine and Dentistry participate on the program. The faculty discuss a topic in their respective fields, then answer questions from listeners. Station WUST offers the University an opportunity to perform an important service for the predominantly black listening audience in Washington's inner city, as well as providing an important community service.

2. Through the Speakers Bureau, the University brings its faculty and staff one step closer to the community through its more than 300 talks scheduled annually. There are approximately 53 speakers in this volunteer service who are faculty members or students in the Schools of Medicine and Dentistry. They speak not only on areas of their expertise, but are available to talk on career opportunities in their fields. The latter topic is especially popular in high schools.

B. EDUCATIONAL OPPORTUNITIES

1. *Health Professions Seminar Program for Local Minority High School Students*

Twice yearly, groups of minority high school students, primarily from the Washington, D.C. public school system, attend two series of five all-day sessions, each related to the medical sciences, emphasizing medical and paramedical career opportunities. In addition, nursing faculty work with juniors in area high schools introducing them to levels of nursing practice, educational opportunities in the Washington, D.C. area and the advantages/disadvantages of each.

2. *Explorer Post of Boy Scouts of America, National Capital Area Council Program*

The program provides the participants with an overview of the services offered at the Georgetown School of Medicine and the Medical Center. It is open to all 14-18 year olds in Washington, Virginia and Maryland high schools. The students attend demonstrations of clinical facilities associated with such departments as orthopedics, surgery, physical medicine, rehabilitation, and ophthalmology. This is the only program of its kind offered by local area medical schools.

3. *Community Scholars Program*

Special courses are provided to strengthen the students drawn from low-income families, who are interested in pre-medical and pre-nursing programs. The courses are selected from those judged to be critical to the students' success during their first academic year, i.e., biology, chemistry, et cetera.

4. *Human Biology Program for High School Students*

The program is designed to enrich the academic levels of high school students in the District of Columbia in the area of human biology; to motivate them to achieve higher academic levels in their studies; to introduce them to careers in medicine; and to provide counseling that enables them to understand better the relationship of medicine to themselves and to their community. It is assumed that a by-product of this program should be the dissemination of information by discussion of the program between participants and their classmates. The program is conducted largely by students of the School of Medicine, although the faculty acts in a counseling and supervisory role.

5. *Continuing Education Programs for Graduate Physicians, Dentists and Nurses*

The Schools of Medicine, Dentistry and Nursing conduct programs designed to provide continuing education for people employed in health services. The School of Medicine, for example, conducts the Thursday Night Medical-Surgical Cardiovascular Conference. It is attended by about 200 graduate physicians and students weekly. Heart specialists, using patients for demonstration purposes, instruct in the diagnosis and treatment of complicated cardio-vascular problems.

The School of Dentistry offers 8-12 courses of 2-3 days duration for dentists and dental assistants. Participants come from a wide area, including the District of Columbia.

In Nursing, where continuing education is likely to become a requirement for annual licensure renewal, the School offers summer and evening courses for area practitioners and educators.

6. *Nurse Midwifery*

In cooperation with the D.C. Department of Human Resources and the D.C. General Hospital, the School of Nursing is offering an educational program in nurse midwifery for area nurses wishing preparation in this extended role. The intention to practice in the District of Columbia is a requirement for admission, and preference is extended to personnel of the Department of Human Resources.

C. MEDICAL-DENTAL SERVICES

1. *University affiliated Center for Child Development*

A multi-disciplinary training center, dealing with mental retardation and related handicapping conditions in children, includes in its three-fold purposes that of "serving the metropolitan Washington community by providing exemplary settings for the care of handicapped children." Additional programs at the training center include dental evaluation and care provided by Georgetown School of Dentistry.

2. *The Area A Community Mental Health Center*

The Area A Community Mental Health Center serves one of the four geographic areas of the District of Columbia and is sponsored jointly by the Georgetown Department of Psychiatry and the D.C. Department of Human Resources. Comprehensive mental health services are provided for 140,000 people of varied socioeconomic levels. The bulk of the emergency and outpatient services is provided at Georgetown University Hospital. The Day Hospital, located in the Georgetown area, has an average of 35 patients in active treatment. The Youth Services facility, which is one block from Georgetown Hospital, includes a day treatment school, outpatient diagnostic and treatment services, a drug clinic, and school consultation services. In addition, the Center operates two satellite clinics in the area. The psychiatric staff of the Center hold Georgetown faculty appointments. Many attending faculty also teach and supervise the residents and students assigned to the Center. Georgetown residents are assigned to all components of the Center; and a major portion of our residency training is centered within the Area A program both in the community and at Georgetown University Hospital.

Medical students are also assigned to most of these components. In addition, 6 third year psychiatric residents provide weekly consultation to the Social Rehabilitation Administration (Welfare Department) of the District of Columbia. Residents are also consulting with the police, a half-way house, and Regency House within the District of Columbia.

3. *Children's Kidney Disease Prevention Center*

The Pediatrics Department, in collaboration with the Division of Urology, operates a screening and diagnostic program for kidney disease for all children in the Washington metropolitan area.

4. *Psychiatric Walk-In Clinic*

Designed to provide "immediate attention to those in crisis," this clinic is staffed by faculty, social workers, residents and students of the Medical Center. It is the only one of its kind in the District of Columbia. A fee of \$10 is charged for initial interview and assistance if the patient can pay. Referrals are made when appropriate. Seventy-five percent of the patients are residents of the District of Columbia.

5. *Home Care Program for Cancer Patients*

A team of physician, nurse and social worker from the Medical Center cares for the advanced cancer patient in his home, thus enabling the patient to be with his family. No charges are made to the patient for these services. 2960 days of home care were provided last year.

6. *Hypertension Program*

This program takes medicine to the people in Washington's inner city. Patients were screened for high blood pressure without cost at black parties, in grocery stores, churches and community centers by physicians and students. In a recent program, more than 3,000 persons were screened. Follow-up treatment is being given on a private-patient basis at the D.C. General Hospital's Hypertension Clinic, operated by Georgetown physicians. Six Eastern High School students were taught to take blood pressure and were sent to check patients waiting in various specialty clinics at D.C. General Hospital. Fifty-four percent were found to have high blood pressure. A similar check run at our own outpatient clinic yielded about 39 percent with high blood pressure.

7. *Outpatient Clinics*

Forty-eight specialized clinics (allergy, eye, pediatrics, et cetera) provide health care for medically indigent persons in the Washington community. Over 40,900 patients visits per year are recorded. Approximately 90% of the patients are black. While the clinics are reimbursed by those who receive Medicare, Medicaid or other health coverage programs, the University clinics run an annual deficit of approximately \$475,000 for non-reimbursable indigent services.

8. *Emergency Room*

The emergency room is open 24 hours a day, providing emergency medical care to all citizens seeking it. At least 20,000 additional patients are seen in the Emergency Room and the Orthopedics Treatment Room each year.

9. *Inpatient Services*

The Georgetown Hospital provides approximately 400 beds for the care of patients. Services are rendered to about 14,775 persons annually, the majority of whom are from the Washington metropolitan area. While the majority are private patients, the Hospital does provide in-patient care for indigents at a cost of more than \$0.8 million in non-reimbursable funds annually. This exceeds by a factor of 4 the legal requirement of 39% free care for hospitals that have received Hill Burton Funds.

10. *School of Dentistry Clinics and Services*

The dental clinics, which are open to all citizens in the community, receive more than 200,000 patient visits annually. While the clinic receives no indigent patients, fees charged are at a minimum of what private care would demand. Over 7,000 new patients are seen yearly. In the clinics, junior and senior students, working under the immediate supervision of the faculty, provide the treatment and care in this program.

11. *D.C. General Hospital Program*

The School of Medicine and the School of Dentistry perform a vital service to the community in this program. The School of Dentistry, for example, provides without cost to the indigent patients. All oral surgery service, as well as treatment of oral infections and extractions, is included. An oral surgery intern or resident is on duty in the hospital emergency room 24 hours a day, 365 days a year, to handle this service. The School of Medicine is involved in the day-to-day functioning of the Hospital. Its faculty, physicians and residents and students are participants. The University provides services in both medicine and surgery and their subspecialties. The staff is also responsible for graduate train-

ing program. Technicians man the laboratories and are paid for by grant monies from Georgetown.

Georgetown's only compensation from D.C. General for service provided is that the space used for research and service is received free.

12. Affiliations of School of Medicine and School of Dentistry at Other Metropolitan Area Hospitals

The faculty and staff of the School of Medicine and the School of Dentistry conduct patient care, teaching and research programs in a number of affiliated hospitals in the Washington area, including D.C. General, the Veterans Administration, Arlington, Fairfax, Providence and Sibley Memorial Hospitals for Sick Children, Columbia Hospital for Women, Children's Hospital and the Walter Reed and the National Naval Medical Centers. Complementing the faculty in the programs are approximately 30 interns, residents and fellows from Georgetown.

13. Georgetown University Community Health Plan, Inc.

The Georgetown University Community Health Plan (GUCHP) is a prepaid comprehensive health care plan offering services to a broad cross section of people in the Washington metropolitan area. The plan is designed to offer enrollees a full array of integrated health services with easy access through "on location" sites near their homes. The plan is family oriented with a strong emphasis on preventive medicine.

The plan is currently operating through two locations: Reston, Virginia, and Edgewood Terrace in Northeast Washington. In addition to the services provided at the two locations on a fee-for-service basis and to privately enrolled subscribers, the GUCHP at the Edgewood Terrace location has contracted with the D.C. Department of Human Resources to provide medical benefits to 2,000 D.C. Medicaid recipients.

The Edgewood Terrace location is the recipient of a Family Health Center Grant which enables it to provide comprehensive medical care to 3,000 medical indigents (that is, persons whose annual income is too great to qualify them for Medicaid, but is less than \$7,000). Sixteen hundred persons are currently enrolled under this program, and it is the only one of its type in existence in the D.C. metropolitan area.

14. Program to Eliminate Major Nutrition Problems

This program is working with physicians in the two Georgetown University Community Health Plan locations to determine the most critical nutrition problems in the communities and set in motion a broad scale attack against these problems. The project will focus on:

a. Treatment of obesity and malnutrition on an individual basis through the doctor/patient relationship in the health maintenance organization. Emphasis will be placed on the critical role of nutrition in preventive medicine. This will be done through heightened physician sensitivity to a person's nutrition needs in addition to whatever other health problems may bring him to the health center. Approved procedures will also be developed for diet control relative to specific diseases.

b. Involvement of the community in the decision-making process and support of the project. All community institutions including civic organizations, government, schools, food industry, families, churches, supermarkets, doctors, will be vital to changing nutrition habits. The man-in-the-street must decide how important nutrition is to him and have access to education concerning good eating habits.

15. Cleft Palate Center

The Cleft Palate Center has been in existence for more than two decades. This is the only facility of this type in the D.C. Area. It is staffed by specialists from all dental and medical specialty areas. These unfortunate patients, both adult and children, are evaluated, treated and rehabilitated regardless of their ability to pay for this service.

GEORGE WASHINGTON UNIVERSITY,
SCHOOL OF MEDICINE,
GEORGETOWN UNIVERSITY,
SCHOOLS OF MEDICINE AND DENTISTRY,
Washington, D.C.

CONTINUATION OF D.C. MEDICAL AND DENTAL MANPOWER ACT OF 1970, P.L. 91-650

PURPOSE OF LEGISLATION

To extend the D.C. Medical and Dental Manpower Act for three years in order to provide financial distress funds for the Medical and Dental Schools in the District of Columbia.

METHOD

By authorizing the Secretary of Health, Education and Welfare to provide funds to the Schools on a formula basis of up to \$5,000 per year per medical student and up to \$3,000 per year per dental student, in accordance with demonstrated financial need.

HISTORY

P.L. 91-650 authorized funds to meet the critical operational deficit of these Schools. Because of this law the Secretary of Health, Education and Welfare has for three years given grants to keep these Schools financially operational.

SIMILAR SUPPORT GIVEN BY OTHER STATES

Twenty-one States have a total of 46 private medical schools. Thirty-three schools receive direct support in twelve States. Twenty-six other States give Regional support. Only two States with three private medical schools do not as yet have support programs but legislation is in process. The average State support is in excess of \$5,000 per student. Dental school programs are similar.

HOWARD UNIVERSITY

Howard University's School of Medicine and Dentistry presently receive operational funds from Health, Education and Welfare. Howard University supports the efforts of the School of Medicine at George Washington University and the Schools of Medicine and Dentistry at Georgetown University to obtain financial distress funds.

NECESSITY FOR THESE FINANCIAL DISTRESS FUNDS

The Presidents of George Washington University and Georgetown University state that without the funds to be authorized by the continuation of the legislation these schools cannot continue in operation. There are fourteen area hospitals directly dependent on the staffs and programs of these Medical and Dental Schools. There are over 10,000 graduates of these schools in the United States in fifty States and the District of Columbia and over 1,700 students from forty-six states and the District of Columbia.

SEYMOUR ALPERT, M.D., *Vice President,*
The George Washington University.
 T. BYRON COLLINS, S.J.,
Special Assistant to the President,
Georgetown University.

ANALYSIS OF STATE SUPPORT OF PRIVATE MEDICAL SCHOOLS

State	Type of school		State support of private school	of in-State	State support of regional private school
	Public	Private			
Alabama	1				Southern Reg., \$3,250 per student.
Alaska					Western Interstate, \$3,000 per student.
Arizona	1				Do.
Arkansas	1				
California	5	3	\$12,000 per student.		
Colorado	1				
Connecticut	1	1			
Delaware					\$7,500 per student.
District of Columbia	1	2			District of Columbia Medical and Dental Manpower Act and HEW appropriations.
Florida	1	1	\$6,500 to \$8,500		Southern Reg., \$3,250 per student.
Georgia	1	1			Do.
Hawaii	1				Western Interstate, \$3,000 per student.
Idaho					Do.
Illinois	1	4	\$6,000 to \$7,000		
Indiana	1				
Iowa	1				
Kansas	1				
Kentucky	2		Subsidy by negotiation		\$3,250.
Louisiana	1	1			Southern Reg., \$3,250 per student.
Maine					New England Board, \$2,500 to \$5,000.
Maryland	1	1	Negotiated annually		Southern Reg., \$3,250 per student.
Massachusetts		3			New England Board, \$5,000 per student.
Michigan	3				
Minnesota	1		\$8,000 per Minnesota resident.		
Mississippi	1				Southern Reg., \$3,250 per student.
Missouri	1	2	Legislation in process.		
Montana					Western Interstate, \$3,000 per student.
Nebraska	1	1	Legislation in process.		
Nevada					Do.
New Hampshire		1			
New Jersey	2				
New Mexico	1				
New York	3	8	\$3,900 to \$6,000		
North Carolina	1	2	\$3,000 per student.		Southern Reg., \$3,250 per student.
North Dakota	1				
Ohio	2	2	\$5,400 per student, approximately.		
Oklahoma	1				
Oregon	1				
Pennsylvania	2	5	\$4,400 to \$7,465		
Rhode Island		1	Special grant.		New England Board, \$5,000 per student.
South Carolina	1				
South Dakota	1				
Tennessee	1	2	Negotiated.		Southern Reg., \$3,250 per student.
Texas	3	1	\$17,282		
Utah	1				
Vermont	1				
Virginia	2	1			Do.
Washington	1				
West Virginia	1				
Wisconsin	1	1	\$4,500 per student, approximately.		
Wyoming					Western Interstate, \$3,000 per student.
Total	56	44			

Source of information: American Medical Association and Association of American Medical Colleges.

GEOGRAPHIC DISTRIBUTION OF CURRENT STUDENTS AT THE GEORGETOWN UNIVERSITY SCHOOLS OF MEDICINE
AND DENTISTRY AND THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND GRADUATES
IN PRACTICE

State	Current students	Graduates in practice	State	Current students	Graduates in practice
Alabama.....	4	45	Nevada.....	8	30
Alaska.....	0	10	New Hampshire.....	14	57
Arizona.....	11	80	New Jersey.....	188	950
Arkansas.....	2	5	New Mexico.....	4	33
California.....	158	910	New York.....	423	1,723
Colorado.....	6	65	North Carolina.....	5	131
Connecticut.....	86	508	North Dakota.....	5	10
Delaware.....	9	44	Ohio.....	33	193
Florida.....	27	376	Oklahoma.....	3	26
Georgia.....	3	71	Oregon.....	4	43
Hawaii.....	2	33	Pennsylvania.....	91	641
Idaho.....	5	38	Rhode Island.....	20	183
Illinois.....	18	105	South Carolina.....	3	56
Indiana.....	8	47	South Dakota.....	5	8
Iowa.....	0	21	Tennessee.....	5	31
Kansas.....	6	18	Texas.....	8	119
Kentucky.....	2	32	Utah.....	40	102
Louisiana.....	1	27	Vermont.....	2	23
Maine.....	12	60	Virginia.....	110	729
Maryland.....	199	1,234	Washington.....	29	109
Massachusetts.....	136	637	West Virginia.....	4	39
Michigan.....	9	106	Wisconsin.....	7	54
Minnesota.....	2	44	Wyoming.....	1	10
Mississippi.....	1	12	District of Columbia.....	108	892
Missouri.....	4	37	Puerto Rico.....	4	88
Montana.....	4	15			
Nebraska.....	0	3	Total.....	1,839	10,863

In summary, Georgetown University, despite all its efforts to meet the costs of medical and dental education from tuition, private grants and from national health legislation, cannot meet these costs without the continuation of the District of Columbia Medical and Dental Manpower Act of 1970.

What if we do not obtain these funds? At best, our medical and dental educational programs will deteriorate, our services to the District and the Metropolitan area of Washington will be curtailed and reduced in quality; at worst, we will have to progressively and finally close out most of our medical center operations, thereby seriously injuring health education and services both nationally and locally.

That is my written presentation, Mr. Chairman.

If I might make a few remarks after having listened this morning to the presentations which I did not have in advance?

Mr. MAZZOLI. Feel free.

DISTRESS FUNDS

Rev. HENLE. Speaking very freely, I think we sort of got ensnared into this distress situation. We came honestly to the Congress and said, we need continuing support. If you look at my first presentation before the congressional committee in 1969 or 1970, when I was asked the direct question whether I regarded this as a temporary distress situation, I said no.

There is a continuing margin of the cost of quality education that is not a matter of distress that cannot be met through private funds which in many cases, such as the Marquette University Medical School and the Cleveland Private Medical Schools are being met by aid of one kind or another from the States; that I would not come to the Congress

and say 3 years from now that we do not need any more help along this line.

After the authorization bill was passed, we had negotiations with the Department of Health, Education and Welfare and we agreed that we would accept funding out of distress funds. I was never in favor of that, but a President does not have much power anymore, so we agreed to go along with that.

Now they are turning round and saying, "Well, you are getting distress funds, how come you are still in distress when the whole point of the distress funding is temporary?"

I honestly have to say to you, if we are going to maintain quality education; if we are going to maintain the high school level of education we have got and the large numbers as we have doubled the enrollment in our medical school, without doubling the price of student cost which I think is another important point, that HEW has raised about our cost.

Under the pressure of the national shortage and in cooperation with the Federal Manpower Expansion program, we agreed to double the number of students and the number of graduates from our medical school. That has increased our cost, but we have done it, I think, at great efficiency now and reduced our cost per student.

I, for one, would like to get out of this distress funding notion and onto a permanent kind of marginal funding that would enable us to continue in operation at a high level of quality. I also somewhat resent the implications that were made here today, and were made previously, that there is something wrong with the administration of our medical center. If HEW will tell me any point in our medical center where there is a surplus, I will guarantee to grab it next Monday and put it into the total funds of the medical school.

For 5 years now I have been looking for surpluses and Mr. McNulty can tell you we just finished budget hearings and he is very bloody from what I have been doing and I think we have to admit it.

JURISDICTIONAL QUESTION

The other ambiguity about us, is, we do come to the Congress, as Mr. Broyhill said so eloquently, because we do not have a State to go to. But we are also a service institution to the Nation, to the States which border us, that is why we repeatedly refer not only to the District of Columbia, but to the metropolitan area.

If you take the percentage of doctors and dentists from Georgetown and George Washington of the total area, this will go up dramatically, I think. And the people that we serve in our clinic, we serve them no matter where they come from, all over the area. The referrals to some of our intensive care sections and so forth, are from Virginia, Maryland, the District, and so on.

So we are a national resource as well as a local resource. And we have kind of a two-fold claim on the Congress, not for preferential treatment, but for treatment which recognizes this special situation and need.

I would also like to mention that Georgetown does operate under a charter of the U.S. Congress.

Mr. MAZZOLI. It does operate under a charter?

Rev. HENLE. Yes, I believe it is the earliest. I do not know whether George Washington is earlier, I think it is the first educational institution ever chartered by the Congress of the United States.

Mr. MAZZOLI. That does put you in a special category.

Rev. HENLE. That is a little public relations.

Mr. MAZZOLI. Doctor?

STATEMENT OF MATTHEW F. McNULTY, JR., SC. D., EXECUTIVE VICE PRESIDENT FOR MEDICAL CENTER AFFAIRS, GEORGETOWN UNIVERSITY

Mr. McNULTY. Mr. Chairman and members of the committee, I am Matthew McNulty, executive vice president for Medical Center Affairs at Georgetown University.

I have a prepared statement and with your permission I hope it will be recorded.

I would like, however, to make a series of comments that I trust will illuminate some of the points made by the committee and some of the discussions by previous witnesses.

[The prepared statement of Mr. Matthew F. McNulty follows:]

PREPARED STATEMENT OF MATTHEW F. McNULTY, JR., SC. D., EXECUTIVE VICE PRESIDENT FOR MEDICAL CENTER AFFAIRS, AT GEORGETOWN UNIVERSITY

Mr. Chairman and the members of this Committee, I am Matthew F. McNulty, Jr., Sc. D., Executive Vice President for Medical Center Affairs, at Georgetown University. I appreciate the privilege of appearing before you today to extend the testimony that our University Presidents have just reported.

My purpose today is threefold:

1. To outline briefly some background with regard to the bills under discussion today; and

2. To describe briefly the irreplaceable service that the Medical School of George Washington University and the Medical and Dental Schools of Georgetown University provide to the District of Columbia to the metropolitan area of Washington, D.C., and to the Nation; and

3. To present briefly an overview of the continuing fiscal problems that in recent years have continually threatened the successful accomplishment of the medical and dental educational, patient service and research responsibilities of these three schools.

Deans of each of the three schools, leaders of national, professional organizations and community representatives will present more specific information.

The Bill before this Committee today, H.R. 11108, is to extend Title III, P.L. 91-650, "The District of Columbia Medical and Dental Manpower Act of 1970". That Manpower Act was enacted through the initiation of the Committee in the Second Session of the 91st Congress. The Presidents of our two Universities have already emphasized for special recognition the work of your Committee on the District of Columbia in the original enactment of P.L. 91-650.

Your Committee initiated a per student, capitation award public policy that subsequently became a national policy for medical, dental and other health science education. Prior to your enactment of P.L. 91-650, Gentlemen, there were not any national student capitation formula programs. Subsequent to your action the Congress enacted P.L. 92-157, "The Comprehensive Health Manpower Training Act of 1971 (HMTA)".

That national legislation (P.L. 92-157 HMTA) expires June 30, 1974. Under the provisions of that law, federal "capitation grants" have been awarded annually to improve the quality of schools of medicine, dentistry, osteopathy, veterinary medicine, optometry, pharmacy and podiatry. Concurrently, all "public" medical schools receive state support. For "private" medical schools, 19 out of the 21 states having these private medical schools, support those schools with some form of state financial assistance.

It is significant to our appeal today to note that the Department of Health, Education and Welfare and the Executive Branch are on record as encouraging

the greater financing of medical and dental education by state governments. Essentially our appeal to this Committee today is for an extension of state-like support authorization—"The District of Columbia Medical/Dental Manpower Act" originally of 1970.

Assisted by the existence of your D.C. Medical/Dental Manpower Act (P.L. 91-650) and the intent of Congress which it represented, the three schools of our two Universities received federal "financial distress awards" from the Department of Health, Education and Welfare for the 1971, 1972, and 1973 fiscal years.

The distress award feature of the national HMTA program was for a limited three-year period (1971-1974). Its provisions expire June 30, 1974. Without this or equivalent assistance, these three schools could not have continued to provide the level of education and patient care which has so benefited the community of the District of Columbia, the metropolitan area and the nation. With the "financial distress award" feature of the national HMTA expiring June 30, 1974, the extension of the D.C. Manpower Act is essential to the continued significant local and regional contribution these schools make to the health problems of society.

The deans of medicine and dentistry, community representatives and the leaders of professional organizations will describe in more specific detail the essentiality of the service rendered to the District of Columbia and the Washington metropolitan area by these three schools. I want only to call to your attention Exhibit I of this testimony.

The District of Columbia Government authorized a comprehensive plan for public higher education in the District of Columbia. A summary report of the study was completed in December, 1972. Three pages of that report have been abstracted as Exhibit I for this testimony.

For the need of professional education in the District of Columbia, this comprehensive D.C. plan for higher education reported "... we do not propose the establishment of new professional schools of medicine, dentistry ...".

In other words, it is essential that quality professional education for physicians and dentists continue to be rendered by the three private universities in the District of Columbia. As I have indicated hereafter, one such higher education institution, Howard University, is already supported through Federal appropriations. Such support assists in the financing of the health science professional schools of that University.

It is notable that the report prepared for the District of Columbia government indicates also "And since medical and dental schools are exceedingly expensive to establish and operate ...".

Also important to note in this context is the urgent plight of the federal health services with regard to recruitment of physicians. Despite recent observations to the contrary, there continues a shortage of physicians in this country. The shortage has multiple dimensions of geography, demography, sociology, economics, specialty education, et cetera; but definitely includes the quantity of physicians available. Recent evidence of this phenomena is identified in Exhibits IIA and IIB.

Since the original enactment of the D.C. Manpower Act (P.L. 91-650), it is encouraging to report that there has begun a rationalization of financing for medical and dental education in our country. It is now possible to perceive a public policy that recognizes at least a five-fold fiscal responsibility for the operation of medical and dental schools. These five concurrent methods for operational resources include a federal responsibility, a state responsibility, a student responsibility, an institutional responsibility and a responsibility for research and development funds—the latter commonly called "Sponsored Program Support."

I have already commented on the National Health Manpower Act (P.L. 92-157). Unfortunately the level of that support at this time does not approach in any way the basic need. The Association of American Medical Colleges recommended that the minimum capitation payment from this national program be \$5,000. The Carnegie Commission on Higher Education recommended \$4,000 per student. The authorizing legislation of this P.L. 92-157 provided for \$2,500 per student. The appropriation authorized only approximately \$1,700 per student grant.

Related to this request for state-like support, it would seem desirable to emphasize the results of a recent study by the Committee on the Financing of Medical Education of the Association of American Medical Colleges (AAMC). That study demonstrated from twelve (12) thoroughly evaluated medical school operational models a cost of undergraduate medical education ranging from a minimum of \$16,000 per student per annum to \$26,000 per student per annum.

Georgetown University School of Medicine participated in the study mentioned. The cost of undergraduate medical education at Georgetown University was eleventh (11th) from the top of those 12 schools. In other words, we were next to last in a study of operational resources expended by 12 prototype schools across the country for undergraduate medical education.

The faculty, staff, students, alumni, friends and administration at Georgetown University are tremendously proud of the health science education, patient care and research contribution made by our medical and dental schools over almost 125 years. We do not want to be and do not intend to be first in the expenditure of funds. We believe strongly that the significance of our contribution to the citizens of the District of Columbia, the metropolitan area and the nation warrants a state-like support of a level higher than next to last!

A brief comment on medical and dental educational financial support from tuition payment; institutional fund raising and funds for education research for new knowledge and expansion of existing knowledge. The three schools have now for 1974-75 extended even further the tuition rates, the fund raising efforts, the successful solicitation of foundations, corporations, alumni, faculty, and friends, much beyond that reported to this Committee upon the initial hearings in 1970 for the bills that eventually became P.L. 91-650. Every possible avenue of tuition income, fund raising income and research income has been exhaustively searched.

The tuition range to students for our three schools now ranks among the highest in the country. The parent universities and these schools have accomplished effective internal economies and effectiveness in organization and management to realize the greatest production of educational endeavors from a minimum of resources.

As evidence of stringent internal management, combined with the seeking and obtaining of financial resources from multiple sources, we emphasize that the amount of funding requested per student in these two Bills for George Washington and Georgetown Universities is no more than the initial law (P.L. 91-650) established in 1970 for a then fiscal climate which has escalated rapidly in the last four years.

Under the original P.L. 91-650 there was a maximum limit of appropriation for the first year of \$6,200,000. Despite inflation, that limit continues to be our recommendation. The capitation ceiling of up to \$5,000 per medical student and up to \$3,000 per dental student is also recommended without increase.

Measured against the \$17,282 per medical student per year for FY 1973 appropriated by the Texas legislature for its private medical school or the more modest \$7,000 per medical student per year by Illinois, \$7,500 by Delaware or \$6,500 by Florida, a ceiling of \$5,000 per medical student and \$3,000 per dental student is a conservative request.

To avoid any misunderstanding of program, I should emphasize that both Georgetown University and George Washington University operate University Hospitals and HMO programs. However, these patient care endeavors are either separate corporations, or, operated as distinct fiscal entities with independent accounting records, income and expense transactions, et cetera, entirely separate from the educational activities of the schools of medicine and dentistry. We are not discussing here any funding for these University Hospitals.

The precedent for state-like support to medical and dental education in the District of Columbia already exists. As I have mentioned earlier, Howard University, a private institution, receives funding from the Congress through the Department of Health, Education and Welfare. These funds assist materially in the support of its health science educational programs. The Vice President for Health Affairs, Howard University, has understood what Georgetown and George Washington Universities are striving to accomplish through H.R. 11108 before you today. Dr. Alexis has expressed that support in a letter of January 2, 1974. He has given his approval for including that letter as a matter of record for the consideration of this Committee. With your permission, Mr. Chairman, I would like to file that letter as part of this testimony (Exhibit III).

The previous Act (P.L. 91-650) and the extension (H.R. 11108) now being requested, require that both Universities submit formalized applications, supported by fully developed cost analysis and verified by independent audit statements of certified public accounting firms. In other words, if P.L. 91-650 is extended as requested here today, financial awards would be fully authorized only on documented, independently audited fiscal reports.

Gentlemen, the need for this support is real; it is immediate. The need continues as essential to the continued level of contribution of our Schools of Medicine

and the School of Dentistry. We recommend an extension of the existing legislation which is consistent with the experience of a clear majority at other private universities in obtaining from their state legislatures, financial support for their medical and dental schools.

We urge your thoughtful consideration and full support for meeting these needs.

I would be pleased to answer any questions, Mr. Chairman. Also, I sincerely thank you and the Committee for the opportunity of presenting this testimony in support of H.R. 11108.

Exhibit I: Three-page abstract from "A Comprehensive Plan for Public Higher Education in the District of Columbia," Summary Report of a Study for the District of Columbia, Arthur D. Little, Inc., December, 1972, pp. 22-23.

PROFESSIONAL SCHOOLS OF MEDICINE, DENTISTRY AND LAW

While we recommend the establishment of four institutions with differentiated roles and a number of professional and graduate programs within those institutions, we do not propose the establishment of new professional schools of medicine, dentistry and law. This is, of course, an important policy issue with significant educational, public service, and cost implications. As such, it is an issue for the Board to address, and, as with all such issues, its ultimate disposition probably will rest with funding sources.

It is true that the absence of medical, dental and law schools limits the comprehensiveness of the recommended public higher education system. But we believe from interviews with officials in non-public universities and Federal and District government agencies that opportunities exist to accommodate substantial numbers of District residents and graduates of public institutions' pre-professional programs in cooperative arrangements and consortium programs with the several professional schools of the District's non-public universities. (We estimate that 85 percent of the District's annual demand for lawyers could be supplied by graduates of those law schools who elect to remain in the District.) And since medical and dental schools are exceedingly expensive to establish and operate, this would enable the District to maximize benefits to its residents within the limits of available resources, an important thrust of the recommended mission statement for the District's public higher education system.

TABLE 3.—FORECASTS OF ANNUAL OCCUPATIONAL DEMAND BY TARGET YEARS, FOR OCCUPATIONS RELATED TO HIGHER EDUCATION, DISTRICT OF COLUMBIA, 1975-85

	1975	1980	1985
Health professions, health services, and paramedical occupations.....	1,279	1,667	2,220
A. Physicians and surgeons.....	129	165	207
B. Dentists.....	38	47	53
C. Pharmacists.....	41	42	44
D. Psychologists.....	13	16	20
E. Osteopaths.....	7	9	11
F. Optometrists.....	6	7	10
G. Nurses, professional.....	384	492	630
H. Nurses, practical.....	218	301	447
I. Medical and dental technicians.....	242	334	489
J. Other medical and health.....	201	254	317

Exhibit IIa

[From the Washington Star-News, Jan. 21, 1974]

U.S. ACTS TO RECRUIT DOCTORS

The Public Health Service, unable to attract and retain enough young doctors for prison and hospital duty since the military draft ended, has resorted to offering scholarships.

The shortage of doctors in the PHS Commissioned Corps is so critical that 26 doctors are needed immediately to fill vacancies in federal prisons and 250 are needed in government hospitals, a spokesman for the agency said yesterday.

"For the future we will look to an expanded scholarship program as a major source of qualified health professionals to operate programs of the Public Health Service," said Dr. Charles C. Edwards, assistant secretary for health in the Department of Health, Education and Welfare.

Edwards said that HEW would make about 700 scholarships available during the current school year to students attending schools of medicine and osteopathy. The emphasis will be on senior year students.

The \$600-a-month scholarships will cover living costs, books, supplies and equipment. The government also will pay tuition and fees directly to the medical school, which could mean an additional \$5,000 of support a year.

Students who complete training will be required to serve a minimum of two years in such PHS operations as the National Health Service Corps, which provides health care to communities with shortages of medical workers and staffs hospitals and clinics caring merchant seamen, American Indians, and others. The NHSC also staffs federal prisons and U.S. Coast Guard medical facilities.

Exhibit IIB

[From the Washington Star-News, Jan. 3, 1974]

DOCTORS SHUN DEFENSE, PHS

A deepening shortage of physicians has hit the U.S. Public Health Service and now will spread to the Defense Department, Nixon administration officials said today.

Since the military draft ended in July, the number of young physicians enrolling in federal medical programs has dwindled rapidly and the trend is expected to worsen this year.

About 200 of the 3,000 PHS medical posts are vacant now, said PHS Deputy Personnel Director James Kissinger and as many as 500 may be vacant by July 1. The vacancies spell trouble for the eight PHS hospitals which treat mostly U.S. Coast Guard men and American merchant seamen, for the Indian Health Service, the National Health Service Corps and other federal medical programs.

Pentagon officials, equally gloomy, predict a "critical physician shortage" this year that will worsen through 1976. By then, they expect about 1,800 vacancies in the department's 14,500-physician staff.

The main reason, Kissinger said, is money.

The PHS offers \$16,000 a year to physicians fresh out of medical school, and the military offers them about \$14,000. But private practice offers these same young physicians an average of \$35,000 a year.

"We're just not finding the recruits," said a PHS spokesman. "Everybody wants to make money."

The PHS traditionally has relied on volunteers, but in recent years most of the "volunteers" signed up to escape being drafted by the military. Now that there is no more draft, there is less incentive for these physicians to volunteer for PHS duty.

To ease the shortage, both the Department of Health, Education, and Welfare, which oversees the PHS, and the Defense Department have asked Congress for money to pay bonuses to young physicians who sign up for federal civilian or military medical programs.

HEW Secretary Caspar W. Weinberger has asked Congress for liberal "special payments" for PHS physicians and a guarantee of a bonus of \$15,000 a year for any physician agreeing to serve more than two years in the PHS.

The Defense Department has asked for bonuses up to \$17,000 a year and \$4,200-a-year "special payments" for young physicians willing to volunteer for military service.

Exhibit III

HOWARD UNIVERSITY,
OFFICE OF THE VICE PRESIDENT FOR HEALTH AFFAIRS,
Washington, D.C. January 2, 1974.

MATTHEW F. McNULTY, JR., Sc. D.,
Executive Vice President for Medical Center Affairs, Georgetown University
Medical Center, Washington, D.C.

DEAR DR. McNULTY: As per our recent conversation, please be certain of my continued personal support of Georgetown in its effort to obtain sounder funding.

Howard does not have a position on this matter, and as such I cannot at this time speak for the University.

I wish you much success.

Yours very truly,

CARLTON P. ALEXANDER, M.D.,
Vice President for Health Affairs.

I proudly initiate these comments by highlighting Mr. Dellum's very excellent questions.

SCOPE OF SERVICES

We at Georgetown believe we are committed to a national program, to a regional program, and we are specifically committed to service with the District of Columbia. But this is one of the ironies that I think brings us here. And, parenthetically, I would echo Father Henle's, our president, observations. We did not come seeking distress. We came seeking support that would enable us to continue to do our job in these three areas, and even to do it better.

The dilemma is that as we seek to meet the needs as described so accurately and precisely by Dr. Standard, we are on the one hand, in need of further commitment, further service, further expansion. On the other hand, the Department of Health, Education and Welfare looks at us, says where are you cutting, where are you cutting, where are you cutting? It is a dilemma from which it is almost impossible, at this point in time, to extricate ourselves.

That is why I think in one strong sense we are here today, to try to indicate that we have the commitment, we have the know-how. We can do more of what is needed for the District of Columbia. We do not have the resources with which to do it. Our hospital, Georgetown University Hospital, I will cite that—I am sure it is the same for the George Washington University Hospital—provided last year \$1.3 million—in round figures slightly more than \$1.3 million of free care. We all know there is no such thing as free care. The payroll must be met. The equipment must be purchased. The supplies must be secured. So that was a financing responsibility that we undertook for those patients in the District of Columbia who do not qualify under the various programs that are available for them. We want to extend this, and as I indicated, we believe we have the ability to extend it.

But it is going to take some form, and we have come to the Congress because so far we have had no other place to go, some form of stable financing that will enable us to join with the District in planning and give us the resources to implement those plans.

Beyond the surface activity—I just wanted to comment briefly, why are we in this difficulty. The chairman put this very succinctly. I think in part it has been answered, but if I could just summarize it as I see it—and I have been in this business for a long time and was privileged to work for a number of years for the Association of American Medical Colleges, through which position I saw all the medical schools of the country. The difficulty has been one of the scientific development that has been tremendous, and the responsibility of the educational process to somehow bring to the student all of the possibilities that that students should know about as a background for preparation as

he goes into residency, specialistic training, and then into practice. It has just grown tremendously. It has become in some instances a one-to-one relationship.

STUDENTS

As Father Henle has indicated, we have gone beyond that in our expansion. As we move to 805 students we will have this September, as we move to that from 400 students, we have not doubled the faculty. We have accomplished what I call, and I think it is commonly known in management circles as economy of scale. This is one of our management accomplishments that we have continuously indicated to all agencies who examine us and for which we are prepared to document on data-by-data basis. That is one of the problems—expansion of our school, expansion by 50 percent of our school of dentistry so that we can better serve the District and this region in this country.

And we also know that this scientific explosion has hit other institutions. As the chairman mentioned, Louisville. The recourse there was to become a State institution. Georgetown and George Washington have a long tradition of private education which we believe strengthens the educational endeavor of the country.

We want to join with a stable tax base and that will enable us to do it better. But it is a scientific development, the impact on education, the enlargement of all the programs that have put the cost to a considerable degree. I will comment later on that.

We do not emphasize that the assistance must come from one source, as opposed to another. It is interesting, though—I have my notes with me of the testimony given in 1970 by the Department, at which time they said substantially the same thing, that it ought to come from another source, and the other source does not seem to us to be any more probable today than it was then.

If I could use the analogy of the distinguished Congressman from Minnesota, we feel like the bride who has been at the altar all these times, and we have not yet gotten a bridegroom.

FINANCING METHODS

A comment on the method of financing. I would differ somewhat with my colleagues from the Department. I think the method of financing higher education to some extent—certainly health science education—is now clear. It is fourfold. It is a Federal financing program.

We have heard some comment about the extension of the Health Manpower Act, the National Health Manpower Act. Parenthetically, I would say it is unclear to me, as I sense it is unclear to the members of the committee, whether it is going to include distress or it is not going to include distress. We are planning now for the next 2 years. I have submitted my budget to the President. He has taken, not a surgeon's knife, he has taken a bludgeon out and just gone through it and said, "McNulty, you are at a zero development level. Until we get resources that is where you are." And I cannot fault that, in the sense that I have no rebuttal. I have no resources to say, "All right, I am getting it here, I am getting it from there."

But we are in a planning stage, which means we are projecting to 1976, and we do not know whether there is going to be distress or

anything else. This means bright, capable young men who want to join the faculty and stay in the District of Columbia are literally going elsewhere, and that is a fact that I can document if the committee would like to have it. Those men who are with us, their morale is not the same level as we would like it in terms of their putting forth greater education and greater service, and they cannot help but be distracted in some way when the future is so uncertain, if not at times almost dark. There is no light involved in it.

The four ways are Federal support, State support—we can quibble, as Congressman Broyhill succinctly mentioned, about the numbers, and we each have a different set of numbers, depending on whether we mean direct State aid or whether we mean State aid for regional medical programs like the southern regional educational board and so on. There are variations of the ways that you count the numbers. I think our numbers are better than they are in the oil industry. We have some difficulty of how and what precisely do you mean by the modifiers.

Aside from that, I think it is clear that a large majority of the States are supporting private education of health, academic health sciences, and intend to do so and apparently intend to expand it.

We are not seeking \$17,000 per student per year, but that is an extreme. The average, though, is above what we are seeking. So State support.

Then there is institutional support. I am going to speak about our management. I got the impression that it was in some sense being challenged.

STUDENTS

Then there is the student support. Why do we not get students from the District of Columbia? For both of our schools of medicine, the tuition this coming September will be \$3,500, and I think that is essentially why we do not get students from any place that cannot afford to pay that amount of money. Our tuition for the school of dentistry will be \$3,400. That means roughly between \$12,000 and \$14,000 commitment for 4 years of education and I think that is a heavy burden that cannot be met by a great number of families in this country. We do not have the resources for large scholarship aid or large other assist in aid. We would like to have. We would like to make commitments to the locality to which we are closely identified. We need the resources with which to do it.

Essentially, these are the four ways of financing academic health science education.

I want to comment very briefly on the number of physicians who remain here. I think it is a common understanding that the number of students graduating from the school of medicine or the school of dentistry is then a measurement of the contribution to any given community. That is not essentially a fact. Most medical students—many dental students and almost all medical students go on to specialty training. Therefore, the real key to a community's need is, can you offer maximum specialty training, because the contribution to the community comes from the intern or resident when they finish their education, largely. In medicine it is 3 years beyond medical school. In dentistry it is half go directly into immediate practice. Another half go on to specialty training.

I would like to point out that we do have residency training programs at District of Columbia General Hospital, where we have been for many, many years, where we will continue to be. There we support both medical and dental educational endeavors. And we have other programs at Sibley, Providence, other hospitals in the community, in addition to our own hospital, some 400 residency programs with specialization that produce, actually, in the metropolitan area, half of the physicians are either Georgetown or George Washington. Half of the dentists are from Georgetown.

This is the method of producing the local needs in terms of the specialistic training, I think. Over the years in the three States, for example, which is not a good measure for the District, because, it takes the State of Virginia to its southern border, the State of Maryland to its northern border. There are 2,748 graduates of the two universities in medicine and dentistry located in those three States. In the greater Washington area, including the practice on the fringe of Maryland and the practice on the fringe of Virginia, there are 1,047 graduates of these two schools. So we are contributing beyond the level of 11 or 14 percent or for Howard's 16 percent. These figures do not include Howard. These are George Washington and Georgetown statistics.

The comment has already been made—the chairman, I thought, had a very pertinent question at the start—why no financing under Public Law 91-650. Our President, I think, has elaborated and elucidated very well. We were prepared to go for financing and we were questioned by the incumbent Secretary, Secretary Richardson, not to seek the appropriation, and through—Congressman Nelsen, we worked out an arrangement that was given in writing, a letter which we can produce for evidence if it is desired, Mr. Chairman, where there was an arrangement worked out that the funding called for under Public Law 91-650 would be financed through distress funding.

One of our reasons, I believe, for being somewhat concerned is the one you mentioned, Mr. Chairman. We know from last year that we were first denied that funding despite the agreement and despite the intent of Public Law 91-650. We are also concerned this year, as we face the understanding of \$10 to \$15 million of distress appropriations and \$31 million of requests. I think that \$31 million does indicate the size of the need. We are speaking for the years following, so I will not mention that.

A comment or two about management reforms. I do not think as we see it the facts coincide with the presentation by the Department, and I call specific attention to the exhibits submitted by our deans of medicine and dentistry for Georgetown University.

In the school of medicine, the practice of the physicians for which they give fees to patients who have third party payment, either insurance, medicare or medicaid, produces for the year 1972-73 \$2,191,000. We do have a faculty practice plan. It is producing sizable income. We do not know how to go about making it produce more income, unless we take those physicians who do not—our physician population, the faculty who do not practice full time. That is not their purpose. Their purpose is education.

But because they are so talented they see patients, and because they want to be an educator they have to maintain excellence. They do practice on a limited basis. We could turn them loose so to speak. We could

say we will have less education and more practice, and that would return more income. But that is not our purpose. And that is what I think Dr. Endicott mentioned when he was talking about excellence. We believe we have excellence of education. We want to continue it. We do not want to create a practice program on Reservoir Road or in our other extensions throughout the community that exists only for the practice of medicine. We could not retain the faculty. They would say, fine, I will go to Connecticut Avenue or Fifth Avenue or rural America or wherever else their interests would take them. They are with us because they are skilled in their scientific knowledge and they enjoy transmitting that knowledge to the next generation and they enjoy the opportunity of research which extends the present knowledge and helps to discover new knowledge.

I would want to make that a matter of record that the reports are submitted and they are in our dental clinic, and the school of dentistry will this year return—it is an estimate, but it was \$949,000 at the end of last year. We estimate it will be between \$960,000 and \$1 million of income, which goes to support all of the departments of the school of dentistry, just as the \$2 million goes to support all the departments of the school of medicine.

So we are perplexed by the challenge made by the department, and we submit the record. We do not say we are doing everything perfectly. We are not infallible. We will cooperate with anyone who will demonstrate additional measures by which we can assist in our own continued excellence of programs.

Mr. MAZZOLI. Mr. McNulty, let me interrupt you at that point.

Are you saying that you are not aware really of what HEW is driving at?

Or are you challenging their conclusion that there is a serious disregard on the part of the two universities?

FACULTY

Mr. McNULTY. From Georgetown, Mr. Chairman, I do challenge their statement that says Georgetown University is doing nothing about a faculty practice plan.

Mr. MAZZOLI. That was the one precise point that was brought up by Dr. Zapp, and of course the chairman and others here asked him for more detail, which we are going to follow up with. And, of course, we would expect that at any time the agency would make that kind of a serious charge they would be able to bolster it. We have asked them for that data.

But beyond that faculty practice, which is the one thing they mentioned, you are satisfied that in other ways your medical center is conducting itself appropriately as far as management techniques are concerned in medical terms, and you feel that you have made a strong effort to overcome the financial distress, and there is very little else that you can do?

Is that basically it?

Mr. McNULTY. I do, Mr. Chairman, and I would like to make two comments in that regard. Comment one, we have discussed this matter with the department, the matter of faculty practice income. And that is why we have changed our exhibit, as some of the members of this com-

mittee will know, from the exhibit we originally presented in 1970 and again in 1972, I believe it was.

We have changed it, broken out the specific money which is collected from the source of the physician's fees. They do not get it. It goes to the institution. And we have broken that out to show it. If we can do more, that is fine.

Cost

I would point out, the department has said, why do you not do more? Then we are in the business, I think, as Dr. Endicott was speaking to directly, how much excellence are you putting into private practice? I would like to call up the other factor of a study of 12 medical schools by the Association of American Medical Colleges as to the cost of medical education. That study appeared in the New York Times and elsewhere several years ago. The range of cost was from \$16,000 per student per year to \$26,000 per student per year. Georgetown has entered practically every study we could get into so people from the outside would look at us. We were in that study, and of the 12 institutions we were 11th by any index that they used. We were next to the bottom in terms of dollar expenditure on medical education for undergraduates medical students.

I submit these two as evidence that we believe that we have exercised consistent and continued excellence, exercised every measure of careful measurement.

We have with us today one of my associates who has just been recruited to the large SUNY program of New York, gaining his reputation in what we have been doing in Georgetown. He is now there as an associate assistant for finance for the four medical centers. He earned, I think, this type of recognition because of the work he and we were doing at Georgetown in cutting every possible point.

Time is running out. I would like to make just a few more comments, if I may, Mr. Chairman.

There has been some stress on why other schools are going down on their requests for distress, and why Georgetown and George Washington are going up. Speaking only for Georgetown, because George Washington has a little different situation, but the same philosophy, the same emphasis, the same need. We are expanding our enrollment, No. 1. We are moving from 400 to 800 students. So this means each year there is an additional increase. It is a zero budget in terms of any other development, but it is an additional expenditure.

Second, I believe—this is a belief, not a fact—I will be pleased to document it if the committee so desires—I believe that every one of the other schools that have showed a decline, it will be possible to demonstrate that in part they are now receiving State aid which has assisted them in reaching that position.

I thank you for the opportunity. I would be pleased to answer any questions.

Mr. MAZZOLI. Thank you.

Dr. Utz?

Dr. HIMMELSBACH. Dr. Utz cannot be here and has asked me, his associate, Clifton Himmelsbach, to present his testimony.

Mr. MAZZOLI. Yes.

STATEMENT OF DR. JOHN P. UTZ, DEAN, GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE, PRESENTED BY CLIFTON HIMMELSBACH

Dr. HIMMELSBACH. I should like to elaborate briefly on our student body, the service rendered to the District of Columbia and the Washington metropolitan area by our medical school, and the cost of medical education at Georgetown.

STUDENTS

Our student body has both a national and a regional character. Thirty-nine States and the District of Columbia are represented among our 780 medical students during the current academic year, 1973 to 1974. Of these students, 33 listed their residence in the District of Columbia, 26 in Virginia, and 73 came from the State of Maryland.

These students are highly selected, highly motivated, and hard working. The applicant pool has grown steadily in size and quality. For the class that entered in September 1971, there were over 5,000 applications for the 205 places. This was the largest number of applications ever received by an American medical school. For the class entering September 1973, the number rose to over 7,500. In our admissions process there are no restrictions or quotas in regard to race, religion, sex, or geographic region. It is important to note that the problem of a national shortage of minority group physicians has received special attention in our school. We have been able to expand considerably our pool of minority group applicants. The result has been an increasing number of minority students in our classes.

In response to the national health manpower problem, particularly the supply of physicians, we have nearly doubled the size of our entering first year classes in the past several years. Georgetown is now the second largest private medical school in the United States.

In regard to service to the Washington metropolitan area, well over 700 of our alumni now practice in the District and in the surrounding Washington metropolitan area. Many more District of Columbia physicians received all or portions of their postgraduate training at Georgetown University Hospital or other hospitals affiliated with our medical school.

Some think that only our older alumni settled in this area. To test this, we reviewed the current location of the 1,687 physicians who graduated from Georgetown between 1950 and 1965. Of these, 283 stayed to practice in the Washington metropolitan area. The principal office of these 283 physicians is located as follows: District, 112; Maryland, 101; Virginia, 70.

COMMUNITY SERVICES

Faculty physicians, house staff, and students serve the community in Georgetown University Hospital and its clinics, the District of Columbia General Hospital, Arlington Hospital and Fairfax Hospital. A strong affiliation exists with the Washington Veterans Administration Hospital. We also have staff and programs at the Hospital for Sick Children, Columbia Hospital for Women, Providence Hospital, and

Sibley Hospital in addition to the Army and Navy hospitals and the National Institutes of Health.

Georgetown's faculty, house staff and students serve actively in the District of Columbia community mental health program. The P Street Clinic for adolescent mental health is operated by our Department of Psychiatry with the Department of Human Resources. In the fall of 1972, a health care program operated by Georgetown opened its doors in a section of Washington's inner city. Lastly, Georgetown faculty are contributing to health care planning in many sections of the District and the surrounding counties of Virginia and Maryland.

A tabulation of annual income and expenses for Georgetown University School of Medicine for fiscal years 1973 through 1977 is contained in the attached exhibit.

NEEDS

A physician augmentation program to run over a 5-year period was awarded to Georgetown, beginning in fiscal year 1971, because our school is committed to a program to greatly expanded enrollments. I direct your attention to line IV of the table, which shows our medical school's need from the provisions of the D.C. medical and dental manpower bill when we will not receive this assistance. This need averages \$2,891 per enrolled student in fiscal year 1975, \$4,933 per student in fiscal year 1976, and \$5,755 per student in fiscal year 1977. I think this is a very important point because we have no idea at this juncture, neither does Dr. Zapp as well, whether this program will be renewed. We have repeatedly asked for information about this since we would like to continue this program. We think it is an important one and we would like to put in an application for renewal as soon as possible.

COSTS

Georgetown costs have been compared in a study of 11 medical schools scattered throughout the country, and a report was published by the Association of American Medical Colleges in October 1973 under the title "Undergraduate Medical Education Elements—Objectives—Costs." The annual cost per medical student in 1972 in these schools ranged from \$16,300 to more than \$26,000. Georgetown's cost was \$16,500. Furthermore, Georgetown ranked 10th in instructional cost, 10th in research cost, 8th in other administrative, scholarly and professional costs, and 10th in the number of full time faculty. Thus, it would appear that the costs at Georgetown are at an irreducible minimum.

In terms of income, the number of students in the entering first year class has been increased from 116 in 1967 to 205 in 1974, and the tuition has been raised from \$1,800 to \$3,500. Such increases in students, 77 percent, has been achieved with only a 33-percent increase in faculty, from 236 to 314. Further increases in tuition for varying reasons are objectionable.

In terms of deficit per student, the amount has dropped 38 percent, from \$3,593 in 1970-71, to \$2,232 in 1972-73. These figures reflect efforts to reduce costs and increase program effectiveness.

Our tuition fees are now at the level of \$3,500 per year. Student requests for loans and scholarships are far in excess of the funds available. I think that shows very clearly the amount of our expenditures.

Obviously, high tuition works serious hardships on our students and their families, and yet pays but a fraction of the cost of medical education.

Many efforts are in progress to bring the escalating costs of medical education under control. We have been able to expand enrollments without proportionate increases in operational costs and deficits. And, in carrying out our educational mission, Georgetown University School of Medicine is privileged to serve all segments of the population of the District of Columbia and the Washington metropolitan area through a network of hospitals, clinics, and community services.

The provisions of this legislation will assure the continuing operation of health manpower resources in the metropolitan area of the District of Columbia that have, in addition local, regional, and national impact. Assistance to Georgetown and George Washington Universities through this legislation is the equivalent of assistance received by private medical and dental schools in 14 States elsewhere through their legislative action. Thank you.

Mr. MAZZOLI. Thank you very much. We appreciate it.

Dr. Murto?

STATEMENT OF CHARLES B. MURTO, D.D.S., DEAN, GEORGETOWN UNIVERSITY SCHOOL OF DENTISTRY

Dr. MURTO. Mr. Chairman and members of this committee, I am Charles B. Murto, dean of the School of Dentistry at Georgetown University. My presentation will touch the following points: One, the program of the School of Dentistry at Georgetown and in the metropolitan area; two, a presentation of the student body and the alumni; three, the costs as they occur at Georgetown University School of Dentistry.

COMMUNITY SERVICES

There has been a long history of service to the D.C. residents and to the residents of the metropolitan area by Georgetown University School of Dentistry since its founding in 1901. The School of Dentistry, with its students and professors, is a major source for dental care in the District of Columbia at the Georgetown University Dental Clinic. The new clinic building was opened in September 1971 and enabled the school of dentistry to meet the challenge of increased dental care needed in the District of Columbia. Our clinic is one of the important resources for dental diagnosis and treatment in the District of Columbia that is available to a very large portion of the area population; namely, the low-income group. Many of the patients come from the inner city areas in the District of Columbia. This new modern facility permits a patient load of presently 170,000 patient visits annually.

Besides the program at Georgetown University Medical Center, there is a very active and rather large program at District of Columbia General Hospital. More than 100 fourth-year students of Georgetown University School of Dentistry are rotated through D.C. General Hospital under the supervision of faculty from Georgetown, together with the supplementary health care provided by three interns and two residents from the Georgetown University advanced specialty program in

oral surgery. The school of dentistry also is in charge of the rehabilitation of maxillo facial patients at D.C. General Hospital. At Veterans' Administration Hospital, there are a number of our faculty who are consultants at that institution and service this hospital. At Children's Hospital, there is an advanced specialty program of instruction in pedodontics for interns and residents under the direction of members of our faculty. In summary, the Georgetown University School of Dentistry is one of the major components of the dental health care system in the District of Columbia.

GRADUATES

Currently, 50 percent of the practicing dentists in the metropolitan area of the District of Columbia are alumni of Georgetown University. It has been noted that there is a marked tendency for a substantial number of graduates of a school of dentistry to locate and practice in the area where they attended school. Thus, Georgetown is a fundamental resource for dentists in this geographical area.

STUDENTS

Our student population at present number 515, will be expanded over the next 3 years to 567 students with approximately 140 graduates annually. This will be a 40-percent increase in this dental health resources, and it will be of direct benefit to the District of Columbia since it allows an increase in dental care by an increase in outpatient load capacity, as well as providing more dental graduates for the metropolitan area.

All of us are aware of the continuing rising cost in higher education nationally. Similarly, the cost of dental education at Georgetown University has increased annually, and this is demonstrated in the attached summary as appendix A. One of the major reasons for this increase in total cost of operation is because of the substantial increase in the number of students enrolled at Georgetown University School of Dentistry. We have large new physical facilities that have permitted us to meet the challenge of providing additional dentists for the metropolitan area, and to also increase our services to the community during the student clinic program of training at the school of dentistry.

However, the increase in cost that accompanies this student increase is rather staggering. It has been necessary to increase the number of professors in all of our departments in order to continue and enhance the individualized student instruction that has become necessary in dental education because of the advance of techniques and scientific knowledge in this field. In addition, the basic science fields of instruction have also had to be increased and will continue to increase because of the large number of students annually.

FACULTY

Finally, we have a high quality and devoted faculty, a fine student body, and an excellent educational program. All of these factors contribute to the excellent graduates that enter the dental profession each year. Funds from this bill are absolutely essential for the survival of this educational endeavor. We, at the school of dentistry, urgently re-

quest your support for the passage of H.R. 11108 as a continuation of the District of Columbia Medical and Dental Manpower Act of 1970.

Thank you for the opportunity of presenting our problems to you today.

Mr. MAZZOLI. Thank you, Dr. Murto. I appreciate your statement.

NURSING SCHOOLS

Let me make for matters of the record an indication that our colleague, Congressman Fauntroy could not be with us today, but of course, representing the District of Columbia, he has a tremendous interest in this. He did file a statement in behalf of H.R. 11108 and its passage. He did indicate in a letter to me, copies of which the other members of the committee have, a concern on his part with respect to the nursing schools at American University and the Washington Hospital Center.

He would urge the committee and the witnesses, if they have any facts on it, to provide some assistance for these two nursing schools, because in the Congressman's opinion—and his information is that these schools have particular financial difficulties and it might not survive. His theory and thought is perhaps what we do could be inclusive of these medical matters.

I wonder if any of the panel was aware and if you have any position and any help for the committee on that.

Mr. McNULTY. Georgetown University has a collegiate school of nursing which would be similar to American University, a little different from the Washington Hospital Center, which has a diploma school of nursing.

We, too, find it difficult to finance that operation. There is a continuing need, particularly in the immediate area as well as nationally, so we have been expanding our school of nursing. We have been doing it by various devices of fundraising and other methods. The cost of education there is nowhere near the tremendous costs we are talking about in the terms of medical and dental education. I do not think I could give any constructive observation other than to indicate I think Mr. Fauntroy's comment is very valid.

The District of Columbia recently, the District of Columbia General Hospital recently discontinued its school of nursing, so there is a real problem in this area.

Mr. MAZZOLI. We have had that same experience at home where the hospitals that have had these training programs for the nurses have abandoned them because they are so terribly expensive.

Father?

Reverend HENLE. I just want to comment on that point. The present administration's proposal for the phaseout of so many programs in support of nursing is in my opinion going to create a national problem unless the Congress reacts and reaffirms some of the programs. I have worked for years for the National League of Nursing to persuade the Congress at every assist to the nursing profession and nursing education was necessary. I thought Congress had arrived at a well-balanced and very intelligent support program for nursing.

I was really terribly disappointed when I saw the President's budget in which so many of these programs in due course would be reduced

to zero. I quite agree, we are sort of hoping that the Congress will reinstate these programs, and if they do, I think at least our nursing school can continue.

The dean of nursing at Georgetown told me that if all of those programs are phased out to the extent that the President's budget calls for, that we could anticipate in several years a 50 percent drop in our enrollment, which I think would put our school in fiscal liability. Of course, we are knocking ourselves out trying to find other money.

It is expensive, but not nearly as expensive as medicine and dentistry because they do do one to one clinical education, particularly in the junior and senior year. But the nursing I agree, that is an excellent point. The nursing problem is really acute. But it is national, not here.

Mr. MAZZOLI. Mr. McNulty?

Mr. McNULTY. Just an aside. One of the things we have done at Georgetown is to get Federal funds to start a nurse-midwife program that would give additional help to the local communities. There are other programs of this type. Father Henle is most accurate. I serve on the executive committee now of the National League of Nursing. Unless we can continue capitation we will see a folding of a number of schools of nursing.

COMMUNITY SERVICES

Mr. MAZZOLI. The Congressman has a second major point. That is something that has been earlier discussed by Congressman Dellums and others on the committee. That is with respect to the responsibility of the two schools in regard to providing health services, either directly or in an indirect fashion in areas of the city that are not adequately served. That, of course, was one of Dr. Standard's major points, in his statement.

Let me then in this connection, to get it on the record, first ask Father Henle and then perhaps Mr. McNulty, are you satisfied, Father, that Georgetown, speaking for your university and its medical center, is doing what it can and is doing as much as it ought to, or if there is still room to go with respect to, as Dr. Standard calls it, ambulatory health care, or the kind of thing we call neighborhood health services?

Reverend HENLE. I am not satisfied that we have yet developed our community health department, which really in the last several years we have been expanding. As you know, we have been in one major effort that has taken a great deal of our time, in establishing the HMO in the District, which will serve a large area, I believe, on this basis. I do not see right now that we would be able at this stage to take on another large section of the District and start another MHO. This is about the biggest burden we carry at the moment.

We do have one at Reston, but in the District I do not know what the number of the area is, we do have a developing one, and our hope is, as we rotate our students through that kind of community service, that many of them may become interested in that type of practice.

You know, part of the mistake, I think, in medical education—and I speak in reverence for my colleagues here—in my opinion, part of the mistake has been that we have so concentrated the training of the physician, particularly the residence years, in hospitals that are fully equipped, where you sit and wait for the patient to be brought in on

a stretcher or walk in and collapse, that they have not had enough exposure of the kind of practice that the old practitioner did, and I think if we can be successful we may bring up a new generation of physicians, some of whom will see a great and fruitful life career in not only locating in the District or inner city areas around the country, but also in rural areas.

Also, I think Dr. Standard made the point that in-hospital care has been escalating in cost. If we can find a way to do preventive medicine, give local attention that does not need hospitalization and give tests locally in neighborhoods, then we can help the entire health program in the United States.

I think if we go in the way that we were going in 1970, we would soon reach a point that, no matter how prosperous the United States is, it really could not finance a total medical program. I think we have been finding better ways, and I hope cheaper ways. Mr. McNulty knows that I keep yelling at our hospital for not finding cheaper ways to do things. I am not really satisfied, but we are moving. We have vastly improved. We do want to do all we can.

Mr. McNULTY. All I could add to that, Mr. Chairman, is the emphasis of the statement that our president made, that the purpose of our extension into the community is a purpose of assistance in terms of community need for health services, but it is concurrent purpose to try to educate, if you will, and indoctrinate and make aware to the medical students of the opportunities for inner city practice.

The reason we selected Reston is because it is financially viable to start something there. It also borders on a rural area. There we hope to demonstrate to the students that there is a satisfying role that can be played in terms of medical and dental practice in the rural areas.

I would say in our present limitations we are doing all we can. We are not doing all we want to do. I believe that we are not doing all that we can do.

Dr. Standard is a member of our faculty. He lectures with us periodically. We have had these discussions back and forth. He is right, I think; we can do more; we have the ability to do more. We do not have the resource with which to do it.

Mr. MAZZOLI. The gentleman from Maryland, Mr. Gude.

Mr. GUDE. In that respect, I was glad to hear Dr. Standard remark that although he found Georgetown and George Washington not doing everything that he thought that they could do, in considering all the other medical institutions across the country who occupy a comparable role, he certainly seems satisfied with the progress that you have been making.

What concerns me is the allegation of HEW—beyond their belief that this is not the proper administrative way for the two schools to receive the funds—that somehow the administration of these two schools is negligent, and there is some fat in their budgets. HEW admits that one way to cut the budget is to lower the quality of care and teaching that you offer the students, and then somehow there seems to be possibly some other areas where you tighten up the administration.

Have they sat down with you and pointed out specifically where there is some fat in the budget beyond reducing the quality of care?

I think it is unfair of them to attack you in both areas. They are certainly entitled in the first area. I certainly question the second area.

Mr. McNULTY. Mr. Gude, the gentlemen seated at the table as witnesses know that each year that we have submitted a distress application, the fiscal as well as the medical and dental professional types have examined our application, have met with us, have challenged us—as I presume they challenge all other distress applications—on the matter of how much are you collecting from faculty practice, what is your ratio of faculty to students, do you need all the space you have that you are doing a job?

I would say the other basic agreement of any business operation, the people, the space, the supplies, the equipment, and to our understanding, we have demonstrated each year to that form of examination that we are meeting the criteria.

As I mentioned previously, when examined nationally on that issue, we are next to last in terms of a dollar expenditure. I think—and maybe I have some prejudice since I am involved in it—but I think that dollar expenditure that is next to last reflects some degree of management.

Mr. GUDE. Thank you, Mr. Chairman.

Mr. MAZZOLI. Congressman Dellums?

Mr. DELLUMS. Thank you, Mr. Chairman.

EDUCATION FUNDING

Mr. President and members of the panel, I first would like to begin and say I appreciate the statement you made with respect to the problems of financing of the medical school. I think to some extent it is even understated. I think to some extent we are facing an extraordinary crisis in the funding of higher education right across the board in the country, first, with rapidly rising costs of education, generally, including education in the medical and dental field; second, what I consider some very serious cutbacks in aid to institutions, aid to students; and third, with the general plight of our economy and the extraordinary inflation. Those families that we often refer to as middle class families who earn between \$9,000 and \$25,000 a year, are finding it increasingly difficult to enroll their children in private institutions. This means that when you look at the larger picture, with the reduced number of students in private institutions for all the reasons that I have just enumerated, there will be a significant push on the public institutions who are also facing essentially the same problems, where we are now trying to fight out a very basic policy position with respect to where we are going in our higher education, that is, our commitment to women and our commitment to minorities. And I see it, those public educations, the drain-off from private institutions and a serious battle where some very important questions are going to be crunch questions that I am not sure this country is mature enough or prepared enough to really seriously deal with until we radically alter our funding and financing of higher education.

So, I want you to know I understand it within that much broader context.

So, coming back to this specific situation, I am in no way interested in thwarting the ability of private education, certainly the schools of medicine and the schools of dentistry, to cut back or to cease the important service that they are providing to the Nation.

The problem that we face here in this committee, it seems to me, is that we find ourselves trying to deal with an important situation that is ostensibly isolated because of the ineptness and the inadequacy of our own national policies with respect to funding, but I know you are aware of the fact that each year we engage in a political colloquy with respect to how much money we are going to give the District of Columbia.

With all due respect to my colleagues on this committee and in the Congress in general, most of us—all of us except for one person—are not intimately involved in that at all. So our discussion of how much money the District of Columbia gets often becomes a very political question that gets bandied about.

As I understand it, whatever funds we give to you two institutions who are, in fact, providing a service, that those funds go against the general District of Columbia appropriation, which means we are in that area of politics on this committee and in the Congress.

I think that is the reason why some questions are being raised, mainly three, as this committee has to assume responsibility of coming up with the funds that go generally against the District of Columbia appropriation, because when we enter that political area of discussion, somebody is going to say in the whole scheme of things we are providing this amount of money and this committee is spending X number of dollars in the District of Columbia.

One question has already been raised. That is what kind of service are you providing, and I am not going to be so arrogant and so presumptuous as to challenge you, but simply to try to hear that we do not think you are quite doing enough, but there are extenuating circumstances.

GRADUATES

My colleague, Mr. Fauntroy, also wrote a brief paragraph that deals with the other two issues that are raised, that you can respond in that context. He states, as I understand the facts, more than 80 to 90 percent of the graduates of both George Washington and Georgetown leave the Capital City to practice elsewhere. I urge you to closely question the advocates of this legislation to determine the level of commitment to recruitment of District of Columbia residents and to the efforts made to entice the graduates to remain in the city.

I am wondering if you could respond to those two questions simply because I think we must have some justification upon which to pass this legislation in terms of its immediate effect on the residents of the District of Columbia.

Reverend HENLE. As I understand it, the funds that we have received in the past several years was unrelated to the amount of money that was appropriated for the District, as I understand it. What we are asking for, we are not asking for a piece of the budget of the District.

Mr. DELLUMS. I understand that. I am saying when we start to deal with that in the extraordinary area of politics—I am not sure what that means any more—is that all those figures all get totaled up and they say, we are doing all these great things for the D.C. residents. Why are these ungrateful folks banging on the table for more money?

It is that general area that I am talking about.

Reverend HENLE. As I said before, I feel that we are in a certain ambiguity resulting from the fact that we do not have a State. The District is a small area. We are a national, international institution. We are a national resource. We are a regional resource. We are a local resource. And we have different claims on the Congress from different standpoints.

I remember the Representative from Maine expressing his willingness to help underwrite us with taxes from Maine because they do not have a medical school, but he had a lot of graduates of George Washington and Georgetown practicing in his State.

So I think we have a variety of claims, to each one of which we can present evidence. I would not want to see any of these three medical schools lose their national stature or their national standard. I think one of the reasons that we can provide such excellent, superior resources is precisely because we have national ability and national prestige, and we draw very bright residents from around the country.

So I would respond, that we are not just presenting ourselves as a District institution. That is part of what we are saying we are, and I will ask the others here to respond in detail to the efforts we have made to recruit minorities, not only from the District and for all of our three health schools.

Again, as Mr. McNulty said earlier, our main problem is lack of financial support. If we had a lot more money for student aid, we would have a lot more inner city girls in our nursing schools, for example. We deliberately built those up, but it is a lack of resources.

Mr. DELLUMS. Before the gentleman responds, I would make one comment.

I tend to agree with you that you are in fact a national institution, and you do provide a national service and also with international ramifications. I think that appropriately it ought to be funded at the national level, but I think due to our ineptness and shortsightedness at the Federal level, with respect to any policy of funding, I think we are totally unrealistic in this area. We spend more money building bombs than we do training young people to provide a humanitarian service.

All I am suggesting to you is because we as a committee are charged with the specific responsibility with respect to the District of Columbia, we need some handle with which to say this institution is willing to reach out to some extent in the general community, not in any way trying to harm your important service to the national community.

Reverend HENLE. As president of the university, I could cite that we certainly do want to do that, and I think the 4 years I have been here I have seen considerable expansion in many ways, not only in the medical school but in other parts of the university, a considerable expansion with regard to our services and our relationship to the District as well as the metropolitan area.

Perhaps you might want to add something.

Mr. McNULTY. Only a practical observation. One of your questions specifically, Mr. Dellums is, do we attempt to influence or persuade those physicians finishing their graduate education and residency training programs and fellowships to stay in the District of Columbia?

Yes, we do. In a realistic way, I do not think it is as productive as it should be. We believe it is not productive because by and large on a

person-to-person basis, if you say, "Doctor, will you not please stay," and the doctor says "Yes," he is most likely or she is most likely either to gravitate to the Connecticut Avenue or to the other location where there is a large cooperative effort on the part of physicians of many disciplines and they can relate to each other with referrals and advice and so forth.

What we need are mechanisms to recruit them to those locations that are not well served now; that were described by Dr. Standard. We believe that it has to be more than just a mechanism of persuasion. We believe one effort, as Dr. Frank Finnerty's hypertension program, which is a national model now of how to go to the front door in the storefront and the church and the block party to reach the public and diagnose, detect undetected hypertension. We hope to attract more physicians into that program.

Our Edgewood Terrace program has already been mentioned. We hope to expand that and intend to expand that to a \$20,000 to \$30,000 capitation prepayment program that will take more physicians and more other health workers that will be a tangible way, when we say please stay, and here is where we want you to practice, and we have a place, we have a program ongoing. They have colleagues. They have all the resources they need and so on, and George Washington is doing the same with their HMO. With our mental health clinic, we have done that. I do not have the statistics, but I have a gut feeling that if we broke down the number of physicians and dentists that we influenced to stay in the District of Columbia through these efforts in the last 2 years—because they are only 2 years ongoing—compared to a year-by-year basis previously, I believe we should have a 50-percent increase in the number we have influenced to stay.

We have brought in others from outside, also, recruited them. The director of our Edgewood Clinic in the city, we have one from California, one from the Far West. I believe we can continue to do this. That type of influence is more realistic than just giving a pep talk.

Mr. DELLUMS. Thank you.

Mr. MAZZOLI. Mr. Nelsen?

DISTRESS FUNDING

Mr. NELSEN. I notice the reference by Father Henle that he from the beginning opposed this business of coming to a distress fund. I thoroughly agree with that. That is a point that I earlier made, and the facts are that here we have these two schools and we sometimes criticize the cutback in funds from the Federal level, and in some cases it is justified because we do have States that supplement through their process. Here we have a situation where you have no other place to go, and so you get cast in the role of a distressed school, and I think this is unfair to the school, and we are negligent in our responsibility here in not having set up something that is more permanent.

Howard University is regarded as a national school, and in view of the fact that Georgetown and George Washington have no other place to go, it would seem to me that looking to the future, we might give some thought to putting these schools in the same category that Howard is, on a national basis.

So it would be a foregone conclusion, every time we meet here in Congress, that we take a little look at your problems as well as to Howard University.

And I wondered if this would be something that you would endorse in view of this kind of approach?

Reverend HENLE. I would certainly endorse an authorization which would drop the distress-funding notion and take the notion of a Federal and congressional responsibility for a very partial funding of the cost of these two medical schools and our dental school, then an appropriation, a line appropriation or an appropriation bill that would then correspond to that authorization, however you call it. I am not a legislative writer, but a line of appropriations that would not take money out of the District and would not have to depend on negotiating with HEW for funding out of some other bill or some other pot. This I would certainly go along with. It would have us an awful lot of time. I do not think my hair would be as grey as it is if we had had that 2 years ago.

Mr. NELSEN. I gather that you would feel, as my associate colleague, that if you were thrown into the District budget to be negotiating, there might be some danger as to the stability of what you would get out of that total fund. I would assume that you would prefer to be cast in a little different role, looking on to the future.

Reverend HENLE. I think I would, I think first of all it would be unfair to the District budget to expect them to take this degree of responsibility for us, and as you say, watching the District budget from the outside, or the sideline. I would be unhappy if we got caught into that kind of a political discussion.

HEALTH MANPOWER ACT

Mr. NELSEN. In the Health Manpower bill, we had a \$2.700 million bill, as I recall, with capitation grants, and I know that George Washington Medical School, your grant was \$1,447,563 as compared to \$259,500 previously, and George Washington University, \$1,047,290 as compared to \$238,000. So we did make some giant steps.

But it is also my understanding that our authorization in this case was far in excess of our appropriation, so that when these schools plan to the future and we give them an authorization, then comes the appropriation and it is much less than that. Of course, that is the legislative process that we are to blame for.

One more question. I wonder what the average dollar flow to medical schools nationwide from all sources, how your dollar input compares to what would be a national average, because this would give us a little basis too as to what we really should do, and maybe you could really supply that if you did not have it immediately at hand.

And then I must add, too, before we leave here, that you are all good salesmen, but you are not nearly as good as one sitting right back of you, Father Collins and Dr. Alpert. They come into my office. We like to see them, and they do a wonderful job. I just want to add my compliment to the statement made by the gentlemen at the table and also to point out that Dr. Alpert and Father Collins do a tremendous job and we appreciate them, and also not only do we ap-

preciate them, we welcome them when they come to our office. They are nice to visit with.

Thank you very much.

Mr. MAZZOLI. I just have a couple of questions for Mr. McNulty.

HEW OVERSIGHT

As I understand, there is a congressionally ordered study of medical school costs which is now in the mill and I think has been delayed one time by—1 year or something, and you were indicating that by any indices Georgetown ranked 11th in this other study.

Are you satisfied that it would rank well in the study that is under way now?

Mr. McNULTY. My comment was more generic. I did say we participated. You are referring to the study by the Science Foundation. We were one of the guinea pigs for trying their test documents and other instrumentations. They decided not to use the test institutions in their study. They felt it would not be as objective as they wanted it to be, so we participated in that developmental stage. We are not one of the institutions that they are studying. We have indicated to them, and I believe George Washington has done the same, I know they have done the same, that as soon as their report is made and they are free we will take their mechanism and do a study of our two institutions also.

Mr. MAZZOLI. To apply against the standards to see how you rank?

Mr. McNULTY. Yes.

Mr. MAZZOLI. As you understand the situation, you are satisfied there will be no great distortion, no unusual circumstance with respect to your two schools?

Mr. McNULTY. For Georgetown I would say no. There will be some distortions, I presume, Mr. Chairman. This was mentioned earlier; we have some departments that are stronger, perhaps than many schools around the country. We have some that perhaps may be weaker. There would be those that would be in total distortions. I do not anticipate any total distortion with comparison to other schools.

Mr. MAZZOLI. Considering that the committee is being asked to enact legislation that puts you and George Washington into a separate category, would there be any adverse feelings on your part, any ideas as to whether or not oversight provisions by HEW similar to those that Dr. Zapp mentioned in the Health Manpower bill would be attached as a provision of this bill?

Mr. McNULTY. Let me see if I understand it correctly.

Do you mean that we would have to document our need and prove it? Is that the overlook?

Mr. MAZZOLI. Whatever the provisions are in the Health and Manpower, which is presently what you have to do to get your distress money, what attitude would you have about attaching that precise language to this bill?

Mr. McNULTY. It would be in the affirmative. We believe we should be responsible in demonstrating an accountable way to any donor, Federal establishment, State institution that gives us funds, accountability of how those funds should be spent and for the need for them.

JURISDICTIONAL QUESTION

Mr. MAZZOLI. Last week—and I guess this is a judgmental question—I accept the fact that many of my colleagues believe that there is an analogy between your coming to us because we sit as a State assembly, and say some other college going to the State assembly in that State, where I think that analogy breaks down is your apparent unwillingness or fear or trepidation about going to Congressman Natcher's committee to justify your money.

In other words, if you went to the State of the District of Columbia, the State assembly would have to go down there with every other supplement for all the ranges of services and say our service is so important that we think it ought to rank in your priorities. You are appealing to us as a State assembly, yet you do not want to get the money from us. You want the money to come, it seems to me, from another source. Would it not be more consistent to say, pass the bill and we will go to Mr. Natcher's committee and get our money from him?

Mr. McNULTY. That is more of a constitutional question than I may be totally qualified to answer, but let me from the observation, from living in this community for a number of years, try to respond, and perhaps if my response is not adequate and in the wisdom of others who might be better versed in it, permit us to submit additional material for the record, I would appreciate it, Mr. Chairman.

First, until just this year, almost, this legislative year of 1973-74, the Congress through Mr. Natcher's committee has been looking at just the operation of the district government, so that Howard University's search for funds, they could not take it there, and we reacted in the same way, and I think it was a reaction that that committee was not the place because they did not intend to fund anything beyond the District Government's operation, and not the peripheral institutions that contribute so significantly to the operation of the total community.

I do not want to be rash. I would only say that it would be my judgment that I would think Home Rule will take, several of you say, a year to get started. I would suspect it would take, after getting started, 2 or 3 or 4 years before it starts to move in some orderly way.

If at some point in time it was demonstrated that that was the process to seek funding as the State mechanism, I do not think I would have any difficulty in recommending to our President that that is the route we go. I do not see that route very clearly now. That is why I think we are here.

Mr. MAZZOLI. Maybe I am not making myself clear. Mr. McNulty. What I was driving at was, if you were in the State of Kentucky and you represented the Georgetown University, which is a private medical school in the State of Kentucky, and you run short of money, you cannot get it, so you go down to Frankfort, to the State assembly and you make your pitch to the appropriations committee down there, or to the authorizing committee and to the appropriations committee, and they say we think Georgetown is such a good neighbor to the State of Kentucky and such an important resource that we will give you this much money, capitation or otherwise. So you come back home and use your money.

We have changed the locale to Washington, D.C., which has no State assembly, so you have exhausted your opportunities to raise money, and so you have got to come knocking at the door of the Government. You get your authorizing committee, which is us, to pass the authorizing legislation. Then you go to the Appropriations Committee.

It would seem to me that if you are coming to the District of Columbia authorizing committee, would it not be consistent to go to the District of Columbia Appropriations Committee for the money which would match the authorization? Except you are telling us that you want the District of Columbia authorization committee to work on your behalf, but you will take your pitch to Congressman Flood, I presume, the HEW Subcommittee of Appropriations for your money.

Is that consistent? Am I wrong, or are we arguing over nothing?

Mr. McNULTY. As I understand it, Mr. Congressman and Mr. Chairman, I do think we have a difference, and let me facetiously say that for many years I had a role with the legislature in the State of Alabama from the University of Alabama Medical Center in Birmingham, and I would go to the legislature on behalf of the president of that board. But I believe, if I understand the analogy, I had two qualities that enabled me to have free access and free persuasion. Whether I succeeded or not was another question. Access No. one was that it was clearly the legal responsibility of the house ways and means and the senate banking and finance committees of that State to consider all the petitions that came before it, and it could give money to Tuskegee Institute, which was a private institution, and to another of other private institutions, and it was doing so, so it was legally acceptable.

Obviously, it was also the second, it was obviously accepted by tradition. So if I had a Georgetown in Alabama, I could go and point to the tradition, I could go and point to the legal capability, and the fiscal capability was also there.

I think when we take the analogy to the District, first, there is no tradition for doing this, and the one tradition that has been established has been established in the way we are pursuing it, that is, to go to your committee, sir, and from there go to an Appropriation Committee that is other than the District Committee.

Second, I have not talked to Mr. Natcher. As I indicated, I am not the expert in this area, but it is my understanding that his view of this is, not only is there no tradition, but that he is not able to meet the needs of the District of Columbia as it now exists, or as it exists before Home Rule. So he would encourage no additions.

I point to the \$38 a day that Dr. Standard mentioned. I think that has been substantially his position. We cannot meet the needs. Now don't bring me another need. That was for hospitals.

So the tradition has not been there. I presume maybe the legal capability is there, but certainly the fiscal capability is not.

Mr. MAZZOLI. Let me ask you a political question.

Do you think you could make your case better with Congressman Flood than Congressman Natcher?

Is that essentially what you are saying?

Is that a fair appraisal of it?

I am not intending to be facetious at all. Believe me, I am not. I am really trying to get an idea because I think this question will be asked.

I particularly feel—I will bring it to my committee's attention here that feeling, that to be consistent we ought to go through the District of Columbia Appropriations Subcommittee. This is where I feel the thread runs straighter than to go to HEW. This is my feeling. That is why I asked you. There may be some other committee that can be persuaded where you will do better, not so much consistency, but would you be assisted?

Mr. McNULTY. I would answer in two ways, in terms of personalities. I have a belief that if the logic of my argument is valid, and given any degree of persuasiveness, that I would hope I would have an equal chance with any reasonable individual. So therefore, Mr. Flood versus Mr. Natcher, I feel are both reasonable, dedicated gentlemen. So on that point there would be no particular preference.

But on the point of the tradition and the fiscal availability and Mr. Natcher's history and the record of saying that there is not enough funds to do the job that now needs to be done, do not enlarge the job, and I would say that our chances would be better then with another committee.

Mr. DELLUMS. Would the chairman yield?

Mr. MAZZOLI. I would be happy to yield.

Mr. DELLUMS. Just for one comment. That is precisely the reason why I asked the gentleman the question I asked before. My thought was that if one did move to that level of consistency, they would approach the District of Columbia Appropriations Committee. It is at that level that projects would start. That is why I raised the question earlier, why I thought it was important for us to have a handle on those figures that at some point may come back to haunt us, as they project an overall figure for appropriation from the District of Columbia Committee.

Mr. GUDE. If the gentleman would yield to that point, I think logic is right in considering the fundamental structure of our system here, but when we considered the home rule bill and considered the Federal payment and had dialog with the District government about their expenses, they were not considering at that time that they have a responsibility as foreseen in the Mayor's letter, of assisting the two hospitals. I think that until there can be an adjustment made in the Federal payment, and in the consideration of taxes in the District, this is the route to follow.

Mr. MAZZOLI. Thank you.

Mr. Hogan?

Mr. HOGAN. Mr. Chairman, I might point out there was another area that was discussed before this committee earlier this year, having to do with the Criminal Justice Act, payments for individuals appearing before the local courts that heretofore had been paid under the U.S. Federal Criminal Justice Act. The question was whether that was going to continue or not. I think the courts generally preferred to continue under the funding of the Federal Criminal Justice Act.

There was a suggestion made, they may want to go for a local Criminal Justice Act. To my knowledge that has not been done. They prefer to go their regular way because apparently that is the path of least resistance.

PUBLIC MEDICAL COLLEGE

I just have one question. There was a higher education study by Arthur D. Little. Apparently there was no inclination or recommendation that there be established a State medical college here in the District of Columbia.

Are you familiar with that?

Mr. McNULTY. Yes, I am, Mr. Hogan.

Mr. HOGAN. That is part of your testimony.

Mr. McNULTY. Yes, it is.

Mr. HOGAN. That there was a recommendation that this not be done.

Mr. McNULTY. Yes.

The study found specifically—or the study recommended specifically many new educational endeavors, but it specifically recommended that medicine and dentistry and I think law, also, but for our sake, medicine and dentistry, seek the medical and dental needs of the District of Columbia through the three existing private institutions.

Mr. HOGAN. Two of which are private, and the other being viewed by those that conduct reports, a national institution, I take it.

Mr. McNULTY. By the three I meant Georgetown, George Washington and Howard.

Mr. HOGAN. Another question here.

How is the military funding program working?

As I understand it, you have a certain number of people at both George Washington and Georgetown who are under the military doctor tuition grant or whatever you call it, program.

Looking ahead, I gather that will terminate.

Is that not correct?

Mr. McNULTY. We expect it to be reduced, at any rate, as a new university for the Military Health Sciences becomes established. Whether it would be entirely deleted, it would depend on the Federal needs for physicians.

I think in part of my submitted testimony I pointed out the desperate need that the Federal services are now recognizing by public announcement in the newspapers of the shortage of physicians. So I would look for it to be drastically reduced, Mr. Hogan.

TUITION GRANTS

Mr. HOGAN. How much do you get in tuition grants for those individuals, do you recall?

Mr. McNULTY. I think it is the regular fees.

Mr. HOGAN. \$3,500 now?

Mr. McNULTY. If it is different, I will look it up and let you know.

Mr. HOGAN. Did it go toward the establishment of a military medical school because they felt the tuition program was not working, or why?

Incidentally, will it be located in the District of Columbia, not in the District but the metropolitan area?

Mr. McNULTY. The decision has been made that it will be located on the grounds of the Bethesda Naval Center in Bethesda. I would only hazard an opinion as to why. The legislation was sponsored for

many years by Mr. Hébert, whom I assume was not rash. He is a skilled gentleman in the Congress—he must be Irish. He had a logic and he had a dedicated purpose and he pursued it. Then there was also a continuing need, the draft had to be continued beyond 1945–46. Now it is no longer in existence. I think there is an evidence they are not able to recruit to the military and to the Public Health Service and the Indian Service physicians, the same difficulty that Dr. Standard mentioned in recruiting them to the District, the rewards and the opportunities and the style of life elsewhere, and I believe by setting up an academy, they would hope in that way to get a group of graduates who would have an obligation for a period of years.

Mr. HOGAN. There is no program similar to the military program for individuals who would agree to reside and practice in urban centers, community health centers, or something like that?

Mr. McNULTY. Not a national program. There are State programs; some States have it. I think we all in the medical education have viewed it as not too rewarding. It did not accomplish the purpose at the level of expectation. I myself believe that it is much more effective to establish some sort of program such as an outreach program of the medical school, an outreach program of a hospital where there is an ongoing entity, where the physician and dentist can feel rewarded in going there.

Mr. HOGAN. Has there been a study of the State programs to determine how effective they have been?

Mr. McNULTY. I know of no national study. I know several States have looked at it. I think there we could identify those States that have this provision.

Mr. HOGAN. Thank you, Mr. Chairman.

Mr. MAZZOLI. Thank you very much, gentlemen. We appreciate your attendance and your help with your information. We thank you.

We thought we would take a break and let those that need to get some lunch and relax a little bit. We will reconvene, unless there is some difficulty for those that are here, we thought we would make it at 2 o'clock, to meet here in this room. Then we will complete our work today. Then we will have all the testimony on the record.

We stand adjourned until 2 o'clock this afternoon.

[Whereupon, at 1:05 p.m., the subcommittee recessed, to reconvene at 2 p.m., the same day.]

AFTERNOON SESSION

Mr. MAZZOLI. The hearings will please come to order.

Our next group is a panel from George Washington University, composed of its president, Lloyd H. Elliott, and Dr. James J. Feffer, vice president for medical affairs.

Gentlemen, it is good to have you; and I appreciate your patience, being with us all day. However, you want to arrange your testimony and your statements.

STATEMENT OF LLOYD H. ELLIOTT, M.D., PRESIDENT, GEORGE WASHINGTON UNIVERSITY, ACCOMPANIED BY JAMES J. FEFFER, M.D., VICE PRESIDENT FOR MEDICAL AFFAIRS

Dr. ELLIOTT. Thank you very much, Mr. Chairman.

I am Lloyd H. Elliott, president of George Washington. Both Dr. Feffer and I have prepared statements which we will choose not to read. Each of us would like to make a few comments, however.

Mr. MAZZOLI. Without objection, these statements will be made a part of the record.

[The prepared statements of Drs. Elliott and Feffer follow:]

PREPARED STATEMENT OF LLOYD H. ELLIOTT, PRESIDENT, GEORGE WASHINGTON UNIVERSITY

Mr. Chairman and members of the committee, I am Lloyd H. Elliott, President of The George Washington University. I want to thank the members of the District of Columbia Committee for the interest and concern you have demonstrated by helping to alleviate the financial distress of The George Washington University Schools of Medicine and Dentistry and The George Washington University School of Medicine.

The passage of PL 91-650, the Medical and Dental Manpower Act of D.C. of 1970, recognized the emergency situation facing the private medical and dental schools of the District of Columbia. The sum of approximately \$1,900,000 was provided for The George Washington University School of Medicine in fiscal 1971 and approximately \$2,000,000 in fiscal 1972. The funds have been provided by the Secretary of Health, Education and Welfare from the disaster grants that were available to him in these years for schools in financial distress. The legislation authorizing these grants expires in fiscal 1974, and it has been forcefully indicated to us that for fiscal 1975 and thereafter our financial needs cannot be met from existing National legislation.

The total unrestricted endowment left in the School of Medicine and Health Sciences is only \$1,122,615. This would not be enough to sustain us for one year and, without new sources of financing, there would be no other funds available to us. The University is hard pressed to make ends meet and there are no University resources for Medical School support.

We appeal to you for necessary support as a private medical or dental school appeals to a state legislature. Our situation is not unique—many states are now supporting private as well as state medical and dental schools. This will be documented by supporting correspondence from The Association of American Medical Colleges.

The University is proud of its public service participation in the District of Columbia and we hope we may continue to serve our community in the years to come. Our growing involvement is not that of education at the expense of the community, nor service to the community at the expense of education. By and large, it is a combination of the positive aspects of both education and service. Some current examples of Medical Center involvement are as follows:

1. *Community Care Center.*—The University's Medical Center, through the Community Care Center, is voluntarily serving the 39,000 residents of D.C. Area Nine. No one is turned away from the Clinic, and charges are based on the ability to pay. Area Nine has a mortality rate 15 percent higher than the average for the District, and a tuberculosis rate 50 percent higher, so the University, by its willingness to care for these citizens, is making an important contribution to preventive medicine and public health. Last year alone, more than 3,500 patients from Area Nine were treated in the Community Care Center, and 30 drug addicts were treated on a methadone-maintenance program which has recently been ex-

panded to cover the full scale of poly-drug abuse in the entire Metropolitan Washington area. The Center admits to the University Hospital any patient requiring hospital care, regardless of his ability to pay.

II. *Health Maintenance Organization.*—A pre-paid practice program, covering 2,000 Medicaid beneficiaries, has been developed under a fixed cost contract with the District of Columbia government.

III. *Low Vision Clinic.*—This Clinic evaluates sight levels of patients with impaired vision and provides visual aids.

IV. *Emergency Care.*—Our Emergency will register approximately 50,000 patients visits this fiscal year. It was recently acclaimed by the Health Facilities Council as the pre-eminent unit for the delivery of emergency care in the Metropolitan Washington area. It is accepting approximately 800 ambulance calls per month—almost as many as the D.C. General Hospital.

V. *Ambulance Personnel Training Program.*—developed in conjunction with the D.C. Fire Department; enhances ambulance technicians' skills in responding to emergency situations.

VI. *Home Care Program.*—for cancer, stroke and chronic disease victims provides a patient transportation center for those unable to come to the Medical Center for treatment.

VII. *Rehabilitation Medicine.*—

A. A computer-assisted cardiac rehabilitation project with D.C. Metropolitan Regional Medical Program in heart disease and stroke provides stress exercise tests for hospitals and agencies in the D.C. area and adjoining states.

B. Provides training and job opportunities in computer industries for severely disabled homebound patients previously considered unemployable.

C. Trains and supervises former addicts to carry out programs of preventive education for school children and others in the community and to enter new careers with probation, parole, social work and rehabilitation agencies.

D. Weekly amputee clinic is available to community health professionals for evaluation, prescription and management of amputees. Prosthetic devices are developed and fitted by staff orthotist.

E. Produces informational brochures to assist community agencies which provide aid to the disabled.

F. Arranges seminars for rehabilitation agencies in the D.C. area on major medical subjects.

G. Sponsors drug abuse seminars for school guidance counselors.

H. Opens doors for health careers for economically disadvantaged and physically disabled youth through summer work programs (100 in 1972, 115 in 1971, and 65 in 1970).

I. Provides training in the treatment of alcoholic clients.

VIII. *Sickle Cell Disease.*—Approximately 60,000 persons in D.C. suffer from Sickle Cell Disease, an inherited disorder for which there is presently no cure. The University runs an active screening program and SCD Clinic and collaborates with multiple channels in the city to educate the public regarding the disease.

IX. *Education and Training Programs.*—

A. Radiology technicians, medical technologists & inhalation therapists.

B. Physicians' Assistants.

C. Nurse Anesthetists, in contracts with three area hospitals.

D. Burdick School programs of Nurse Aids & Operating Room Technicians.

While the primary purpose of The George Washington University is learning, we are aware that where education and community service can be combined there are more beneficial results for all. The financial support of this Bill is essential. The continuation of our ability to offer medical service to the Washington community is dependent upon the viability of our School of Medicine and Health Sciences.

PREPARED STATEMENT OF DR. JAMES J. FEFFER, VICE PRESIDENT OF MEDICAL AFFAIRS, GEORGE WASHINGTON UNIVERSITY

Mr. Chairman and members of the committee, I am Doctor James J. Feffer, Vice President for Medical Affairs of The George Washington University.

Our School of Medicine and Health Sciences serves as an abundant source of well-qualified medical practitioners for the District of Columbia and its environs. George Washington University medical graduates practice in all the 50 states (Exhibit A) with the greatest concentration being in the Metropolitan Washington area: 434 in the District of Columbia; 374 in Maryland, and 204 in Virginia.

Reference has been made to the essential health services our faculty and students provide to the people of Washington. Core programs of care and education are conducted by George Washington University's staff members and students in a number of hospitals—Children's, Columbia, D.C. General, George Washington University, Fairfax, Holy Cross, Naval, St. Elizabeth's, Veterans Administration and the Washington Hospital Center. Elective educational programs are offered at Walter Reed Army Hospital, National Institutes of Health, Armed Forces Institute of Pathology and the Malcolm Grow Air Force Base. Our resident physicians in the University Hospital and its affiliated post-graduate programs number 320 doctors who render specialized medical care to the community. Our training program for Physicians' Assistants numbers 60.

At a time when every effort is being made to increase our output of physicians and allied health personnel, we face the persistent threat of inadequate funds to support our programs. Unfortunately, we cannot continue our present academic role without the resources of this proposed legislation.

The fiscal plight of our School of Medicine is one on continuous operational losses (Exhibit B) that come as a result of conditions beyond our control. Despite efforts to reduce expenses, to effect economies, and to increase income from various sources, our deficit remains about \$5,000 per medical student per school year. Our annual tuition has risen to \$3,000, making it one of the highest in the country. In the absence of a guaranteed loan program, we have reached the limit in tuition increases.

Our current 564 medical students come from 42 states and the District of Columbia (Exhibit C). With the trend in medical education toward exposing students to clinical situations early in their careers, the students are an integral part of all our service programs. They learn to become physicians by working with patients in the clinic, the hospital, the emergency room and in their professors' offices. All of our community health programs depend heavily for manpower on students, house officers and faculty.

We are in the second year of operating an academic health maintenance organization, a pre-paid health plan that is of benefit to the residents of the District of Columbia regardless of whether they are publicly or privately insured. While this is essentially a community service, it fulfills an important academic model for future practicing physicians.

Through vigorous effort University officials have raised \$10 million to match federal funds for much needed and long awaited facilities for the School of Medicine, which became available to us in May 1973. Although capital funding has been completed, we seek the assistance of this legislation for operational support so young men and women can continue to be educated in these new classrooms and laboratories. Expanded programs for physicians' assistants and nurses, and modern postgraduate educational procedures for practicing physicians are important features of our immediate future.

Since 1825 The George Washington School of Medicine has served with distinction as a local and national source of capable, practicing physicians. We seek support of this legislation in order that our School may continue its vital role in the preparation of future physicians to serve the health needs of our community and our country.

Thank you, gentlemen, for the privilege of appearing before you.

EXHIBIT A

DISTRIBUTION OF CIV. GRADES BY STATES AS OF 1/1/72

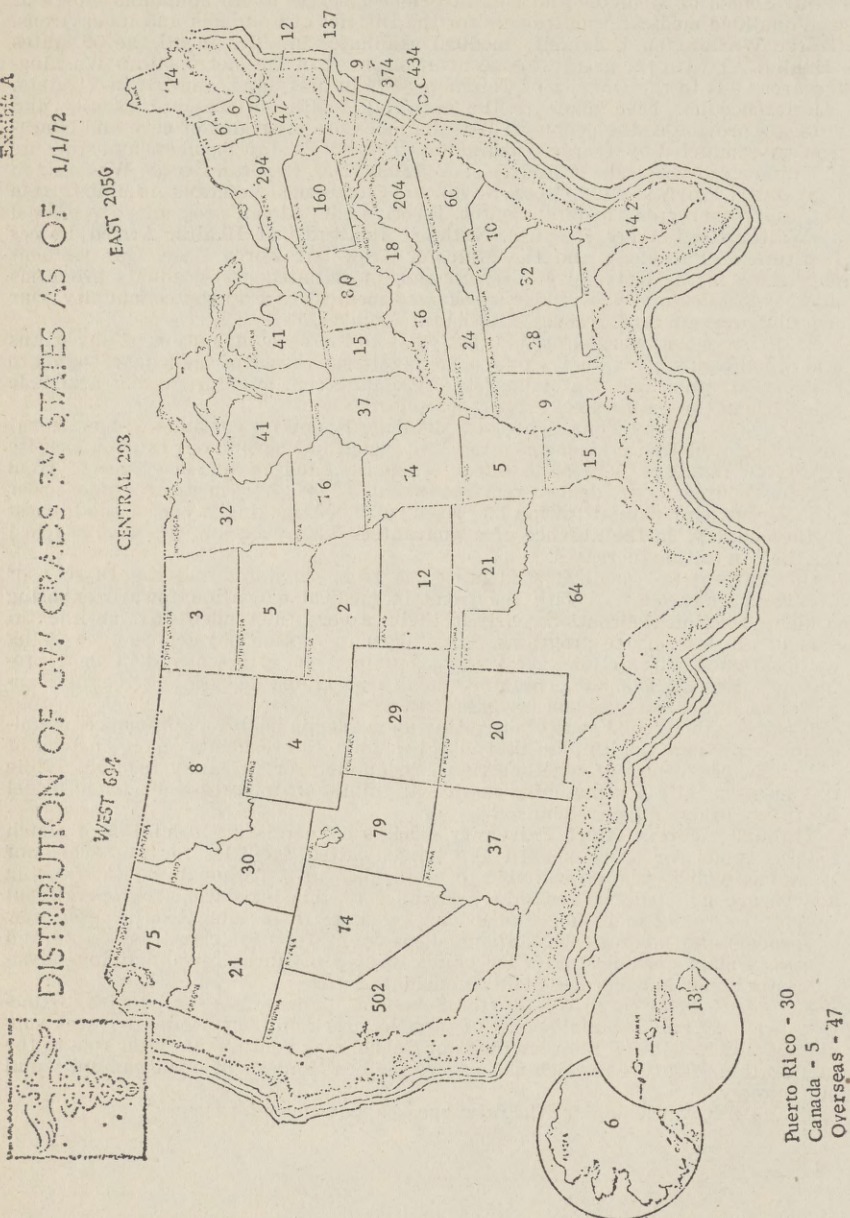


EXHIBIT B

SUMMARY OF ACTUAL AND PROJECTED INCOME AND EXPENSE, FISCAL YEARS 1972-73 THROUGH 1976-77
SCHOOL OF MEDICINE AND HEALTH SCIENCES

	1972-73	1973-74	1974-75	1975-76	1976-77
Income:					
Tuition and student fees	\$1,921,763	\$2,412,500	\$2,712,000	\$3,000,000	\$3,176,000
Endowment income	144,107	145,000	157,000	158,000	159,000
Sponsored programs	6,194,194	6,000,000	6,378,000	6,773,000	7,193,000
Education and development funds	447,985	450,000	478,000	508,000	539,000
Federal capitation grant	911,855	1,047,290	1,141,000	1,173,000	1,173,000
Gifts and miscellaneous income	526,273	599,000	600,000	650,000	700,000
Student aid	135,040	135,000	136,000	138,000	140,000
Total operating income	10,281,217	10,788,790	11,602,000	12,400,000	13,080,000
Expenses:					
Faculty salaries	2,706,938	3,192,000	3,368,000	3,553,000	3,748,000
Nonacademic salaries	2,901,403	3,209,000	3,385,000	3,554,000	3,732,000
Staff benefits	583,943	697,000	735,000	775,000	818,000
Equipment	769,158	825,000	875,000	928,000	984,000
Operation and maintenance of plant	711,204	1,883,000	2,100,000	2,307,000	2,535,000
Other direct costs	2,259,901	2,483,000	2,632,000	2,790,000	2,957,000
Medical center and university services	998,563	1,147,000	1,219,000	1,295,000	1,375,000
Student aid	135,040	135,000	136,000	138,000	140,000
Total expenses	11,066,150	13,571,000	14,450,000	15,340,000	16,289,000
Deficit	(784,933)	(2,782,210)	(2,848,000)	(2,940,000)	(3,209,000)
Distress grant received	706,459				
Enrollment	516	564	580	620	620
District of Columbia manpower need per student			4,910	4,742	5,176
Percentage of operating deficit to total expense	7	21	20	19	20

¹ Application submitted for DHEW financial distress program award.

Attendance at George Washington University School of Medicine; 1973-1974;
Geographical Distribution of Students

Alabama	3	Nevada	4
Arizona	3	New Hampshire	1
Arkansas	1	New Jersey	47
California	45	New Mexico	2
Colorado	4	New York	106
Connecticut	26	North Carolina	4
Delaware	2	North Dakota	4
District of Columbia	40	Ohio	13
Florida	7	Oregon	2
Georgia	1	Pennsylvania	24
Hawaii	1	Rhode Island	4
Idaho	4	South Carolina	1
Illinois	6	South Dakota	4
Indiana	6	Tennessee	1
Kansas	3	Texas	1
Maine	4	Utah	21
Maryland	84	Vermont	1
Massachusetts	13	Virginia	25
Michigan	6	Washington	20
Minnesota	1	West Virginia	1
Missouri	2	Wisconsin	1
Montana	3	Wyoming	1

Graduating Class:

	Number
1973-74	117
1974-75	147
1975-76	148
1976-77	152

Dr. ELLIOTT. Then we can proceed to whatever questions you might have.

First of all, let me say that some of the statements made this morning I think need to be amplified or perhaps even corrected.

UNIVERSITY SERVICES

The statement was made from the Departmental representatives that George Washington has been—and I put it in quotes—“giving some thought to the establishment of a clinical practice plan,” which the implication being that if it were done, it would help to alleviate our financial problems.

Let me say George Washington University put into effect a clinical practice plan in 1969 which has been refined somewhat since then, but which we believe to be one of the most sophisticated in the country. And judging from conversations which I have had with university presidents who have medical schools under their administration of which they envy us for the progress that we have made in this very difficult area. And a number of them have confided in me that they still have such ground to cover. And I might say that it is sometimes a painful route to follow.

It disturbed me this morning to hear the representative of the Department suggest that we had not come that route, that we are only giving some thought to it, when this has been known, made known to the Department representatives in each of our annual reports and in supplemental reports since that period.

Mr. MAZZOLI. Doctor, at this point let me maybe suggest this. Do you think they have a different concept of what that practice program is? You might be talking about apples and oranges possibly. Or do you think it was an intentional disregard on his part of the fact that you have been supplying that; and it was his intention to look the other way?

Dr. ELLIOTT. Someone has not been looking at the reports that they have been asking for if they do not know about this plan.

Mr. MAZZOLI. Assuming that they do know about this plan, do you think it does not suit their standards for the kind of program they are looking for?

Dr. ELLIOTT. I would not venture an opinion on that.

Next, let me say, Mr. Chairman and members of the committee, that you have heard in the testimony today a number of commendatory comments regarding our service programs in the greater Washington area—the Outreach, the HMO's, and all of those things.

In my prepared statement I have listed a number of these but have not tried in any way to be inclusive.

Let me say in answer to one or two questions that were raised, we are committing more of the university's resources now to health care Outreach programs than we can afford to do. We are stretched beyond our resources.

Let me add, we do not know yet, in spite of all our experimentation—and we are still doing it—we do not know yet how to deliver health care in a satisfactory fashion to the inner-city poor, nor do we as a nation know how to deliver to rural America.

I think a number of us are experimenting. We are trying; we are working hard at it. But if we give the impression that we are resolving or answering this problem, I think we would be misleading. We do not attempt to do so.

Mr. MAZZOLI. Out of curiosity, is one of the ways that you are studying to deliver health care to the inner city and to the rural areas just letting doctors open up offices as traditionally doctors have opened up offices, or is that so completely traditional as to be a discarded concept?

By that then, part of your responsibility then would be to train doctors to open up offices, hang up a shingle, as doctors have done since Hippocrates, and open up a practice.

GRADUATES

Dr. ELLIOTT. I am sure you are aware that around the country where the States have tried to influence the location of the trained physician after he completes his training, such programs as existed in the Rocky Mountain States, which more or less demanded that the trainee return to his home State, these programs have been general failures; because as was mentioned this morning, the specialization which comes after the M.D. degree has been acquired often leads a practitioner to an entirely new location.

To get back to your question, experience seems to indicate that in the final analysis the individual physician locates because of a whole complexity of factors brought to bear on what his objectives are and where he thinks he may best do whatever it is that he at that point, perhaps at the end of the specialty training, selects to do.

And there is no question that this leads to a concentration in a number of areas.

Mr. MAZZOLI. I agree that they locate because they are near a hospital or they locate where they have friends of another specialty and they can work together; but do you think it is possible for a doctor to make a good living opening up, in the traditional sense of the word, an office downtown somewhere like a neighborhood doctor, or do they have to have some kind of unique delivery approach and some kind of storefront mentality? Or do you think it can be otherwise?

Dr. ELLIOTT. I really do not know. I came to George Washington from the State of Maine. When I left the State of Maine there was something like 115 communities publicly seeking services of a doctor.

Mr. MAZZOLI. 115.

Dr. ELLIOTT. They were unable to attract a physician who hopefully would come in and hang out his shingle and develop a practice. Some of them were offering rather substantial financial rewards to do so. Very few were successful.

Putting the inner city in the context that you have mentioned, I think this boils down to the individual physician, man or woman, and what he or she feels is the area of service of his or her own skill, interest, and so on.

Much has been said this morning about the dual purposes to which these two schools serve, the national interest and the local community. I think this is the position that both schools will continue to try to resolve; and I do not believe that either school expects to turn its back on local responsibilities, nor does either school expect to become other than a national resource.

In this regard, George Washington—as well as Howard, as well as Georgetown—is an institution chartered by the Congress in the interest of the Nation; and we find ourselves often being requested to be a local institution when citizens in groups of the greater metropolitan area of Washington want services. And we find ourselves being referred to as a national institution when we want their financial support, and vice versa.

Mr. MAZZOLI. It is a tenable situation.

Dr. ELLIOTT. With all due respect to the Congress, perhaps it is one of your problems in trying to respond to our needs. In a real sense, we are two kinds of institutions, local and national.

Finally, I just want to say and reiterate what has been said in a number of ways. If we do not get this help, the quality of our work will be eroded. And I will add that the quantity, in terms of the various programs which we are conducting, will have to be cut back.

And as has been indicated also, the difference between what we are seeking and what we are able to provide from already known sources would require substantial increases in tuition if we are to continue operating at this level without this help that we seek.

Mr. MAZZOLI. Thank you very much.

Dr. Feffer.

Dr. FEFFER. It is very nice of you to have us with you, and I, too, will not bore you with reading my formal statement.

I would like to take the few minutes available to me, however, to respond to a number of comments and allegations made this morning, the degree that I am able, to correct the record.

COSTS

One of the first matters which I heard was that we—George Washington University—were bucking the national trend in terms of the cost of educating medical students. I can assure you that the per capita costs of educating medical students has been on the increase in every single medical school in the country. There is no way that this can be corrected.

As evidence of this as far as George Washington University is concerned, may I comment first that I think it was also stated that the schools which had in the past applied for distress funding, who are applying now for lesser amounts of distress, were implying that they were less distressed.

I would call to your attention to 1971 when we received the distress legislation and \$2.1 million in 1972, \$1.8 million in 1973, the year just closed. We were awarded \$1.3 million, but through many, many frugalities, we returned all of this except \$784,000. In other words, we returned about \$600,000 of the distress awarded that was in our bank account. So we have made every effort that we could. I could easily have spent it, sir, on improving our programs and our quality; but we determined that we were going to operate as efficiently as we possibly could.

In 1974, you will notice that we are budgeted at \$2.7 million deficit; and I would like to explain this to you, if I may. The previous figures I indicated represent actual expense, actual expenditures. In 1974, \$2.7 million is the prospective budget. I would anticipate that it is not

unlikely that the expenditure level in 1974 will be down closer to \$2 million rather than \$2.7 million.

Why have our costs increased then from the \$784,000 this year to what will take \$2 million next year? We have within recent months moved into a new medical school. It is a huge building. The cost of heating and lighting and housekeeping that building alone will be in the neighborhood of \$1½ million. The cost of heating and lighting and housekeeping placed on the building on H Street that some people referred to as a dump was a little in excess of \$230,000. It is a difference of more than \$1 million just for the heating, lighting, and housekeeping of that budget.

Then it comes to the increase of operating. Our oil costs alone can be predicted to go up this year in the neighborhood of \$125,000 to \$175,000 just by virtue of the increased cost of fuel. And we have also heard in relation to this—Mr. McNulty, I believe, commented in this regard—that those schools that are now in less distress, if you will, from the standpoint of Federal support, are in fact receiving increased support. They are not getting along on less money. It is not costing less to educate a medical student elsewhere.

PRACTICE PLAN

President Elliott commented about our practice plan; and I did play a major part in the establishment of it in GWU. I think it is one of the most sophisticated practice plans in the country. It is looked at with envy by other institutions. It is a completely controlled plan. Every single clinical faculty member, without exception, is on a salary. We completely control. There are no exceptions of any kind.

This practice plan in fiscal 1973—and I use this year because it is a year that the books have closed; and I can give you precise plan figures—this practice plan in fiscal 1973 delivered patient care to the gross extent of something in excess of \$10 million. Out of that \$10 million, after paying 40 percent of all clinical faculty costs, including support services, secretaries, overhead, and everything else, funneled out an excess of \$2.8 million.

If it were not for this very sophisticated clinical practice plan, instead of \$800,000 last year, it would have been in the neighborhood of \$3½ million.

Mr. MAZZOLI. If your plan is nationally renowned, and it is producing several million dollars applied to your deficit, how is it the HEW people ignored it, did not know about it, can there be such a communications gap between those auditors who come aboard your place, and those reports that they had before them?

Dr. FEFER. These have been contained and had been contained in our distress grant application. These figures certainly have been available to them.

Mr. MAZZOLI. Have you had a chance to talk with anybody from HEW about this? About this remarkable oversight or oversimplification?

Dr. FEFER. I did not know it until I heard it this morning. I intend to talk with people in HEW.

Mr. MAZZOLI. It is the first inkling you have had that your plan which has national renown, and is one that you put together to produce

considerable money for your school—it is the first word you have had, that it is, not even given the time of day?

Did you have any previous indication?

Dr. FEFFER. The first indication that I had that they would interpret our practice plan operation in this form, the way they did, we had with HEW discussed the practice plan on many occasions. I had pointed out to them on many occasions how helpful the practice plan was and how much more trouble we would be in without the cooperation of the clinical faculty.

It is not easy to get back to the position where you have been making two and three times as much money practicing across the street, to conform to this type of operation.

Mr. MAZZOLI. Thank you.

Dr. FEFFER. The next comment I would like to make regarding the implication that there is a deficiency in administration perhaps almost of the point of dereliction of responsibility.

Again, in this regard, I think we have a very, very efficient forward-looking administrative structure which other medical centers are looking at, and which has received considerable comment in the world of academic medical training centers.

The absence of forward planning I acknowledge, and we are guilty, but we have had no opportunity for forward planning. We just count how many dollars we are going to have to spend, even this year that we are in, we have no idea how much money we are going to have to spend. Consequently, we cannot forward plan.

One of the tremendous advantages that will accrue if we are able to obtain legislation prospectively authorizing funding of our medical school, will be the opportunity to forward plan within the number of dollars that we do know are available.

I would like to emphasize that I believe it was Dr. Zapp who said that we had already received \$1.2 million capitation money toward our next year's budget, and I will qualify and correct that statement.

Really, the capitation money at \$1.2 million that we have received, was for this year's budget. It is including that \$1.2 million. It is after including that \$1.2 million that we had a deficit that we had submitted in our reports to you.

That \$1.2 million is in the budget. It has been received and has been committed, if not largely spent. My own opinion, and Dr. Elliott has referred to this, the economy that we have already effected, we have effected to a point where any additional economies would be disquality to a point where I fear very much that we would be accredited by the accrediting agency to continue in operation. We cannot ignore the fact that cost and quality are inseparable.

DISTRESS FUNDING

I would like to emphasize, and you have already alluded to this, that the distress authorization does expire this year. Not only capitation, but also special project grant authorization expires next year. All of this at a time when we are attempting to prepare a budget for next year for fiscal 1975 to present to our board of trustees for their approval, the month after next, in March. It is quite an impossible situation.

I might point out that all of the relatively few schools in the United States who do not receive State support are a number of heavily

endowed institutions—Harvard, Yale, Washington University—Danforth Foundation just gave them another \$60 million on top of all else they had.

So there are reasonably endowed institutions who do have income to that source that is not available to us. I would like to emphasize that we have not permitted any increases in existing programs in the medical center in the past 2 years. We have not permitted the introduction of any new programs which would cost dollars.

The faculty and their entire support staff salaries for the past 3 years have been restricted to an overall maximum of a 5½-percent increase per annum.

Our student faculty ratio is closer to the bottom of the other 118 schools in the country, rather than near the top, and our tuition is pretty much at the top of the scale. So I think we have strained each of those factors to the degree that it can be done.

STUDENTS

The comment has been made, by implication, through questioning that we have admitted relatively few District of Columbia medical students. And albeit this is certainly true, we have begged, we have borrowed, and we would almost steal, to get more students from the District of Columbia. But without the enrichment, if you will, of loan and scholarship program funds, and without additional funds to establish remedial programs to assist students from underprivileged areas, we are very severely constrained. We have not been able to go beyond what we have done.

A very, very minor point, but one which emphasizes a question I think Congressman Nelson raised, are you not getting many military students whose costs are being covered by the military.

I am sure you appreciate the military is meeting the cost of medical education to the identical degree that other students who go to our school are. The military merely pays tuition. When we admit a military student to our school, there is a cost to us of the difference between the tuition of \$3,000 and the actual cost of education.

So here we are. The carrot has been extended, of course, making students do more, get yourself more involved in the community, but the fact remains that there is a stick there, too, and we are just not able to get around it without this type of fiscal support.

Thank you very much.

Mr. MAZZOLI. Thank you very much, Dr. Feffer.

FUNDING THE LEGISLATION

Let me ask you, would you think it logical, illogical, useful, or unuseful, to consider going to the Appropriations Subcommittee for the District of Columbia to fund this bill, assuming that the committee would feel that this is useful legislation?

Dr. FEFFER. I think it would be logical only if the appropriation to the District of Columbia were restricted for this purpose.

Mr. MAZZOLI. You would not be able to fend for yourself at the board table with every other individual?

Dr. ELLIOTT. This really puts us in the dilemma, looking at these schools from the point of view of the Appropriations Committee of the District, that is, are you fundamentally a District institution.

As I indicated earlier, we are doing our best to live up to our local responsibilities. We are, however, continuing as an institution in the national interest. We would put them in the position of having responsibility which extends beyond the District of Columbia and to have them have to defend dollars to us which in some measure go to support national programs where other parts of their budget go solely for District programs.

Mr. MAZZOLI. If you have enough opportunities as I understand it, there is something like \$100 million that has been provided for in total authorizations for the Federal share above and beyond what is now being claimed for the support of the District.

For instance, Congressman Natcher's subcommittee would not be hampered by the fact that they could not get this money if they felt that it was necessary. Do you feel that you could not make a claim to Natcher because he would not appreciate the role that you are fulfilling here? That he would cast you in terms of a local resident of a local operation entirely and in that connection not see that you have any priority? Is that the problem?

Dr. ELLIOTT. I think Dr. Cheek was saying something in this context that applies both to Georgetown and George Washington when he said a few days ago that Howard is a national institution and therefore to continue to have it financed through HEW is the desirable thing to do.

I think that he was saying, in a very real sense, that the committee or the organization that allocates the money to his institution or to ours, either of ours, will, to a measurable degree, exercise authority to provisions and influence over its programs.

It seems to me that Congressman Natcher notwithstanding, this is not a personal matter, this is a position of the committee. It seems to me that over a period of time the committee would be compelled to put additional pressures upon us to give more attention to the local than to the national.

I do not believe that it can be avoided.

Mr. MAZZOLI. You do not think that would be desirable?

Dr. ELLIOTT. I do not think that would be desirable.

Mr. MAZZOLI. Would there be any kind of comparable situation, Dr. Elliott, that on any other private school in another State who is required to go to the State assembly of that State and make its claim even though it has a kind of national character, or is George Washington and Georgetown in unique positions in that there is no other school like yours in the country?

STATE PROGRAMS

Dr. ELLIOTT. The kinds of aids given to private schools in other States varies a great deal. For example, some States, and I believe New York is one, gives aid to the University of Rochester which is a private medical school, not on the basis of how many citizens of New York attend the University of Rochester Medical School, but on the basis of how many students they educate in the Medical School of Rochester.

I think that I am correct on this that they are taking their chances that those that are recruited by the University of Rochester, and come there for the training, that enough of them will remain in practice in

New York State that it will be worth New York State's time and money to invest in them and therefore get the continuing service of the trained physician.

Up in Maine, for example, the small State of Maine pays for students that have places reserved for them over at the University of Vermont Medical School. The hope is—and here it is difficult to determine the answer—the hope is that at least some of those students will come back to the State of Maine to practice after they have had that kind of public money from the State level invested on their behalf.

As I indicated earlier, this is not proving to be very satisfactory.

JURISDICTIONAL QUESTIONS

Mr. MAZZOLI. Do you think that your role and character is so unique, Dr. Elliott and Dr. Feffer, that we ought to have a special law that will take care of you and Georgetown?

Dr. ELLIOTT. Of course, you are asking nonlawmakers to pass judgment on a kind of law—

Mr. MAZZOLI. Not really, we are not talking about law here, we are talking about a state of mind. We are talking about an attitude that we have about not just medical education, but the type of education that your school is producing and we are talking about the admission of a school, as you would view it, and in that connection not on the idea of what is good law and what is not and how you word it.

Do you think that the place you occupy, along with Georgetown, along with Howard, that you have such an unusual position along with your sister schools, in the country that notwithstanding their own need and their own problem, to go to their State assembly and try to lay their case on the table, in some cases that is not a persuasive situation?

Notwithstanding this, that you still feel that out of the Federal dollar you should be served?

Dr. ELLIOTT. That is our feeling.

I would say, Mr. Chairman, that these three schools, Howard, Georgetown, and George Washington, do not yet have a State assembly to whom they may turn. Howard does exist and is continuing to be served by, as I understand it, your so-called line item in HEW's budget which calls for a Federal appropriation each time.

I think that our position, the uniqueness of it, if you please, being located in the same District which is not yet a State, which does not yet have the powers of a State, there is no other comparable location in the 50 States. So, in that sense, we are unique.

I feel that by accident of our location, our founding and the way the District has grown, and the Federal Government has grown, I think these three schools are indeed unique.

Mr. MAZZOLI. Dr. Elliott, you just said "which is not yet a State that does not yet have its elected government." Assuming that it does get an elected government, and I think the referendum will carry, are you prepared at some point in the future in some years of time to make your case to the State assembly of the District of Columbia?

Dr. ELLIOTT. Mr. Chairman, being very candid, I think it will take a number of years for the District of Columbia government and the Federal Congress, to come to such a meeting of minds, and such a division of responsibility as to reflect locally in a completely self-governing, mature State-type government.

And, until that time, I do not believe that we can compare the District of Columbia government fairly to the Commonwealth of Pennsylvania, or to the State of Ohio, or to Kentucky or to the other operating States.

Mr. MAZZOLI. If it takes 7 or 8 years to reach a position where there is a government in the District of Columbia, elected government, which has its sea legs and has gone through a few shakedown cruises and is back home, do you think then you can make your pitch?

Do you think that then you can make a point to this assembly? Because it is on the basis that there is not now a State assembly, no State level within the District of Columbia here today—as I understand, the argument is made as if we were members of a State assembly.

So if it takes 3 years, 10 years, do you think that you will ever reach the point where you can make your argument to a State assembly in the form of a city council, or do you always think you will be at the Federal level?

Dr. ELLIOTT. I would say, in the foreseeable future, we would be looking to the Federal level of government, not that the District of Columbia government will not mature in those years.

But let me just illustrate that. After 7 or 8 years, the so-called Federal payment to the District of Columbia is likely to be unique and differing there from the Federal payment to other State-level jurisdictions, if for no other reason than the magnitude of the Federal establishment here in this State as compared with the other 50 States.

GRADUATES

Mr. MAZZOLI. Dr. Feffer, you were here when Dr. Standard talked earlier today about the plan that he had thought about and suggested with respect to a program comparable to the public health service in inducing young people from this community to go to medical school and then stay in this community to practice. And on the basis of forgiveness of loan. Does that plan seem feasible to you?

What are your thoughts on it?

Dr. FEFFER. Mr. Chairman, it has been tried in a number of locations. It has been tried by the Sears, Roebuck Foundation and a large number of medical students who are given this opportunity if they would practice in certain unserved areas. And the payoff has been very, very small.

The youngsters have preferred to go into the urban, suburban areas if you will, make a living and pay the loan back. Mr. McNulty and I were talking about that during the break and he was commenting on his experience in Alabama where that experience was very similar.

I think Congressman Nelsen is closer to the answer than anybody else and this is working. I received my training in Indiana, and now the Hoosier student marries a girl from a small town, learns to fish and hunt and those things that can be considered as part of the culture in that geographic area, and this has had an effect.

But to provide loan forgiveness and expect a student to practice in an inner-city ghetto area, I think has been tried sufficiently; we have to accept the fact that it does not work.

Incidentally, it is not only in this country, but other countries.

PARAMEDICAL PROGRAM

Mr. GUDE. Along this line of improving the level of health care in the inner city, how can you at George Washington best help in the field of paramedical personnel? I imagine this is something that you share?

You were speaking with regard to Dr. Standard's testimony of hospitals all around the country—

Dr. FEFFER. We, and Georgetown, are both involved in a rather extensive training program in the paramedical area. We now have a physician's assistant school, if you will, to which were admitted 30 students last year and an additional 30 this year. In other words, 60 students.

We have training programs in innumerable paramedical areas and we are starting next year a training program for primary physicians through support from the Robert Wood Johnson Foundation.

But the problem is the same and this has been experienced and reviewed very carefully, one has to look at the physician's assistants who have been graduated from the Duke program which was one of the first to be started. We are finding that they too are tending not to go where they are really needed, but perhaps to go where it is more attractive to live.

I do not know the answer. Dr. Elliott responded to a similar question of the chairman a few moments ago while you were out, and I would certainly agree with his response.

We do not have the answer yet to the delivery of health care to the inner city.

Mr. GUDE. Not getting too far afield, but in this respect, can the school system of the city, at the high school level, do anything to steer students in the direction of paramedical careers?

Dr. FEFFER. There is no problem. There is no lack of individuals who are interested in going into the paramedical field. We had—and I would like to check this before it becomes officially a part of the record—but my recollection is we had close to 1,000 inquiries and some 600 or 700 formal applications for 30 slots in our physician's assistants program when it started last year. So there are people. There are youngsters in particular who are interested. We are currently just becoming involved with a program that will concern the rehabilitation of the aged in an attempt to bring those that had some experience in the past back into the health delivery care field.

We are thinking of and working with various methods of approaching this problem, but the answer to it, I do not know but you do know that we are serving very substantially from our base on Washington Circle. We are serving very substantially a population of 40,000 people. We are providing guaranteed care. Our emergency room is open 24 hours a day. We are receiving the largest number of ambulance visits per unit of time in the city other than D.C. General. We are very close behind D.C. General. They are running about 1,000; we are running 800 a month.

So, to the degree that people are brought to the facility, if you will, we have responded to the community needs.

Mr. GUDE. I appreciate that. I was thinking to the extent that we develop, indigenous services, among individuals who are interested in paramedical careers and send in their applications, are a large propor-

tion of those from the city? And do you feel that those that would come from the city and complete their training would then go elsewhere?

Dr. FEFFER. They go out to the country where the air is clean and it is not polluted; yes, I am afraid so, sir.

And let us not forget that the problems of the inner city is not merely a matter of having one doctor per 1,000 residents, if you will. No matter how many doctors per 1,000 residents you put into the inner city, unless one meets the deficiencies that otherwise exist, the contribution of these doctors will be minimal. It is a major, big social problem.

Mr. GUDE. Thank you, Mr. Chairman.

Mr. MAZZOLI. Congressman Stark?

Mr. STARK. Thank you, Mr. Chairman.

I wanted to get some statistics, and if they are not readily available, I would appreciate it if you could send them on later.

STUDENTS

I would like to know, for 1972, or 1973, whatever is your most recent academic year, how many District of Columbia residents applied for admission relative to total applicants, and how many were accepted, relative to total applicants.

I would like to also have a racial background over the past several years—

Dr. ELLIOTT. What breakdown?

Mr. STARK. Racial.

As I say, I would like to have these statistics as part of the record. You would just send them on later in the form of a letter, I would appreciate it very much.

[The information requested follows:]

THE GEORGE WASHINGTON UNIVERSITY,
Washington, D.C., February 1, 1974.

HON. ROMANO L. MAZZOLI,

Chairman, Subcommittee on Labor, Social Services and the International Community, Committee on the District of Columbia, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN MAZZOLI: At the hearings before your Subcommittee on January 24th relative to H.R. 11108, a Bill to extend for three years the District of Columbia Medical and Dental Manpower Act of 1970, Congressman Fortney H. Stark requested information concerning certain racial and geographical distribution characteristics of students admitted to The George Washington University School of Medicine. The information, for the years 1971, 1972 and 1973, is tabulated on the enclosure.

As a result of participation in the Association of American Medical College Application Service (MCAS), for the fall class of 1974 a substantial increase in the number of applications is anticipated from minority groups and, hopefully, this will result in improved enrollment relationships.

Again, I would like to express my personal appreciation for the opportunity to appear before the Subcommittee on Labor, Social Services and the International Community in support of legislation in behalf of the Schools of Medicine of George Washington and Georgetown Universities.

Sincerely,

JAMES J. FEFFER, M.D.,
Vice President for Medical Affairs.

GEORGE WASHINGTON UNIVERSITY—SCHOOL OF MEDICINE AND HEALTH SCIENCES, SELECTIVE ENROLLMENT DATA

	District of Columbia residents			Blacks			Total applicants		
	1971	1972	1973	1971	1972	1973	1971	1972	1973
Applied.....	53	85	77	71	115	69	2,966	4,320	5,114
Accepted.....	14	16	12	12	16	19	307	310	379
Enrolled.....	9	9	8	5	14	6	124	143	151

THE GEORGE WASHINGTON UNIVERSITY,
Washington, D.C., February 6, 1974.

HON. ROMANO L. MAZZOLI,
House of Representatives, Longworth House Office Building, Washington, D.C.

DEAR MR. CONGRESSMAN MAZZOLI: At the hearings before your Subcommittee on January 24th relative to H.R. 11108 (a Bill to extend for three years the District of Columbia Medical and Dental Manpower Act of 1970), interest was expressed in the University's undergraduate recruitment program for minorities. Enclosed is a statement giving the University's minority student program.

Sincerely,

SEYMOUR ALPERT, M.D.,
Vice President.

MINORITY STUDENTS AT THE GEORGE WASHINGTON UNIVERSITY

The University actively recruits disadvantaged minority students residing in the District of Columbia. Representatives of the Offices of Admissions and the Educational Opportunity Program visit every secondary school in the District, explaining what academic, financial, and personal support is available for these students and soliciting applications for admission and assistance. The program has been in operation since fall, 1968, and through fall, 1973, 227 students have enrolled, averaging at least 40 each year out of freshman classes ranging from approximately 1,000 to 800. The University has set aside as much money for these tuition grants as it does for scholarships awarded to incoming freshmen on the basis of scholarship and financial need.

In order to strengthen any academic weakness evinced by these incoming students, the University offers an academic support program consisting of a free summer orientation session and a free tutorial program primarily for the first-year student.

Outside the District of Columbia, the University recruits minority students with the same intensity that it recruits nonminority students, visiting secondary schools in urban areas from which we have received inquiries or applications. Each applicant receives the same attention and consideration.

The greatest single handicap in the recruitment of disadvantaged students from outside Washington is the lack of sufficient financial aid funds. These students generally need more money than tuition grants to cover their expenses, and these costs cannot usually be covered by the regular federal and nonfederal funds available. It is interesting to note that out of the 808 students awarded federal aid during the 1972-73 academic year, 146 were minority students, 111 of whom were black.

As a result of a student survey conducted during registration fall, 1972, the following racial breakdowns were reported:

	Undergraduate	Graduate	Unclassified
American Indians.....	33	35	16
Black Americans.....	259	398	152
Oriental Americans.....	71	161	46
Spanish surnamed Americans.....	75	63	23
Other.....	4,831	6,014	1,589
Total.....	5,269	6,671	1,826

GEORGETOWN UNIVERSITY,
MEDICAL CENTER,
Washington, D.C., February 1, 1974.

Hon. ROMANO L. MAZZOLI,
Chairman, Subcommittee on Labor, Social Services, and the International Community, Committee on the District of Columbia, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN MAZZOLI: Thank you for your thoughtful letter of January 30.

I am pleased to reiterate my verbal comment to you on Thursday, January 24 at the end of the hearing on the proposed extension of the District of Columbia Medical-Dental Manpower Act when I sincerely complimented you and your staff on conducting an excellently run hearing. Well done!

Earlier this week I sent to Mr. Stark (Honorable Fortney H. Stark, M.C.) the statistics which I understood he wanted. A copy of that submission is attached. If any additional information is desired, please let me know.

Thank you and the Committee for the opportunity of testifying. Best personal wishes.

Cordially,

MATTHEW F. McNULTY, Jr., ScD.,
Executive Vice President for Medical Center Affairs.

Attachments:

GEORGETOWN UNIVERSITY,
MEDICAL CENTER,
Washington, D.C., January 30, 1974.

Hon. FORTNEY H. STARK,
*U.S. House of Representatives,
Longworth House Office Building, Washington, D.C.*

DEAR CONGRESSMAN STARK: In accordance with your request at the hearing of Thursday, January 24, before the Subcommittee on Labor, Social Services and the International Community of the Committee on District of Columbia, I have attached several statistical summaries which I trust will be of assistance to you and the other Subcommittee members:

1. The applicant and enrollment statistics for the School of Medicine freshman class entering September, 1973.
2. The applicant and enrollment statistics for the School of Medicine freshman class entering September, 1972.
3. The applicant and enrollment statistics for the School of Medicine freshman class entering September, 1971.

As I believe these statistics demonstrate, there has been a deliberate effort on the part of Georgetown University to give a favorable consideration to both applicants from the District of Columbia and minority applicants. In that regard for the class admitted in September, 1973, only 2.7 percent of all applicants who applied were accepted and enrolled. Of those D.C. applicants who applied, 10.5 percent were enrolled. Of the black candidates who applied for this entering class, 7.0 percent were accepted and 1.8 percent actually enrolled.

We have indicated to the Committee previously that many of the "accepted" minority candidates report to us that they must enroll elsewhere because of the very favorable student grant-in-aid programs available from competing medical-dental school institutions.

We do not say that our emphasis on additional consideration of minority applicants and District of Columbia applicants is phenomenal. We say only that we are doing more and intend to continue to do so.

Additionally, as I shall indicate hereafter, we have exercised vigorous leadership in trying to develop an enlarged pool of applicants of both D.C. students and minority students. This effort has been rewarding but on a slowly developing basis. We intend to keep emphasizing this consideration, and we believe over the years ahead both the applicant pool and those admitted from the pool will increase.

Since the late 1960's Georgetown University Medical Center has exerted a conscious effort to gain private funds from foundations and individuals for the development of programs to benefit the economically deprived medical and dental school aspirants in the United States and specifically in the District of Columbia. We believe that these efforts have contributed significantly as indicated hereafter.

In 1969 Georgetown University Medical Center sought and received a grant from the Josiah Macy, Jr., Foundation to implement a program aimed at identi-

ying students from the socio-economically depressed areas of Washington, D.C., who had demonstrated potential to enter medical and other health professional schools. The program sought to help those students entering medical and other health professions by providing to them a variety of supplemental learning experiences and financial assistance. The program was enthusiastically developed by the faculty. We believe that this program successfully enhanced the future careers of a number of minority students in the District of Columbia. Unfortunately as indicated previously, our Schools of Medicine and Dentistry did not benefit proportionately because many minority students who sought admission and were accepted at Georgetown eventually enrolled in other schools. The substantial benefit of student grant-in-aid offered by other schools with which Georgetown must compete just is not possible from the limited resources available to this institution. Thus, many students are lost to Georgetown.

Another result of our vigorous effort in the area concerns a successful application to the Alfred P. Sloan Foundation. The award from that Foundation has enabled presentation of three on-going programs as follows:

1. *A Compensatory Education Program for Entering and Enrolled Minority Medical Students.*—This is a ten week full-time educational program covering the basic medical sciences with an emphasis on reading and study skills in the area of medical terminology.

2. *A Summer Research Fellowship Program for Pre-Medical Students From Predominantly Minority Institutions.*—This program is designed so that a group of pre-medical students can assist basic science and clinical faculty members of the School of Medicine in various research projects during the summer for which financial support is given to the students and significant motivation and learning for the student are important benefits.

3. *A Health Professions Seminar Program for Local Minority High School Students.*—This program involves a twice-yearly seminar in which minority high school students, principally in the public school system of the District of Columbia, attend two series of all-day sessions on medical sciences emphasizing medical and paramedical career opportunities.

A third area of endeavor by Georgetown University has been the seeking and obtaining of funds from University benefactors to provide annual scholarship support for black minority medical students. These scholarships have been awarded since 1970. They represent a continuing source of financial aid support for this group of medical students. Unfortunately, despite strong and continuing efforts, these funds have been small in comparison to the opportunity we have to provide financial resources to many more minority students.

I trust that the foregoing information and attachments will be of assistance. Should you wish additional information, please let me know. Thank you very much for your careful and perceptive review of our testimony and your consideration of the urgent need of the Schools of Medicine and Dentistry at Georgetown University and the School of Medicine at George Washington University for financial support.

Cordially,

MATHEW F. McNULTY, Jr., Sc.D.,
Executive Vice President for Medical Center Affairs.

GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

SEPTEMBER, 1973

APPLICANT AND ENROLLMENT STATISTICS

	Total Applicants	Total Minority*	Total Black	Total D. C.
Total Number of Applicants	7,661	454	386	95
Total Number Accepted	4.7% 356	7.5% 34	7.0% 27	14.7% 14
	2.7%	2.0%	1.8%	10.5%
Total Number Enrolled	57.6% 205	26.5% 9	25.9% 7	71.4% 10

*Includes all minorities except Orientals.

GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

SEPTEMBER, 1971

APPLICANT AND ENROLLMENT STATISTICS

	Total Applicants	Total Minority*	Total Black	Total D. C.
Total Number of Applicants	5,041	126	70	52
Total Number Accepted	7.0% 352 4.1%	17.5% 22 11.1%	21.4% 15 5.7%	17.3% 9 13.5%
Total Number Enrolled	58.2% 205	63.1% 14	26.7% 4	77.8% 7

*Includes all minorities.

GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

SEPTEMBER, 1972

APPLICANT AND ENROLLMENT STATISTICS

	Total Applicants	Total Minority*	Total Black	Total D. C.
Total Number of Applicants	7,014	347	200	92
Total Number Accepted	6.1% 424 2.9%	8.1% 28 2.9%	9.0% 18 4.0%	14.1% 13 7.6%
Total Number Enrolled	48.0% 205	35.7% 10	44.4% 8	53.9% 7

*Includes all minorities.

TUITION

Mr. STARK. I have one other question.

It is a philosophical question that may be somewhat general, but applies to all professional schools, or do you think it would be within the realm of possibility for schools such as yours to come up with a tuition figure which would, in fact, be a pay-as-you-go amount?

It seems to me that if you eliminate endowment and say that you really properly account for future costs such as pension costs, retirement costs, refurbishing and expansion, that the cost accountants ought to be able to come up with a figure that it would cost two or three times your current tuition. Then, working out some kind of Federal funding system, albeit loans or grants, to students with the idea that these funds be repaid over a lifetime, much the same as social security is repaid to replenish the fund, instead of a hodge-podge, of a patchwork grants both to you and the students?

It is an idea that we have toyed around with—at least I have—I just wonder if school administrators in this type of professional school, what kind of reaction you would have to a program of that nature?

Dr. ELLIOTT. A package of financial aid to the student that would recognize overall costs; that would relate that overall cost to the tuition charge; would be a workable solution to the problem, provided the stu-

dent has access to the scholarship funds and/or the loan funds in sufficient measure to push him along. In other words, not to scare him out of even applying, but to make it clear to the student growing up that medical education is within his reach, because no matter what his economic status, there will be funds there if he qualifies.

Mr. STARK. I hope that you are doing the same kind of slip that I do in referring to these students in the masculine gender, only out of the long, ingrained habit, and that you really intended to say he or she.

Dr. ELLIOTT. We are an affirmative action institution, thank you.

The problem here is twofold. One is that the youngster from a low-income family, may just conclude with the big figures, that such is unobtainable by him or her. If one gets over that barrier, then the barrier problem is allocating scholarships, grants or direct support in some kind of balance with loans that also make it manageable.

And here we are talking about a minimum of \$10,000 a year, and from there on, up to perhaps \$25,000 or more. And this certainly gets into the realm of national policy with response to the manpower/womanpower needs in let us say the health care field. Thus far our experience has not been such as to encourage this route because—and I think nearly all of our programs of financial aid to college students or to post-high-school students, in technical and vocational areas as well, we have never really been able to make available enough funds for either scholarships or loans to meet anywhere near the need.

Therefore, the philosophy, if you please, has not in our opinion received a fair test of its viability.

Mr. STARK. Thank you.

Dr. FEFFER. This is a very complex subject, Mr. Stark, which we and others, including the Association of the American Medical Colleges, have looked into very intensely, which is as a matter of fact the year before last—I will try to get that report from the Office of Science and Technology.

They reviewed through their staff, in great detail, one goes all the way from what do you do with a student who drops out of school at the end of the second year, through the negative dowry effect on the female student, if you will, how does one manage this; to various levels of forgiveness, or various levels of sacrifice in terms of community responsibility.

I think Dr. Elliott would agree that if we arrived at that point where nothing remained but to close the school, that we would try that before we would close the school.

Mr. STARK. I often thought that the figures were fairly clear as to the economic benefits that accrue to not only colleges but a variety of professional graduate education, and I imagine it is always true, but individually they may not.

It seemed to me that private schools, that alumni have a certain duty to repay which I am sure they forget about immediately after they graduate, and they do not repay nearly in proportion to the benefits they received.

It seems to me that we could just even it out and spread it out over an economically productive life, it would be fair and obviously then in areas where there are social benefits, you offer forgiveness as an inducement—for a number of years, it does not have to be a total amount—but for part of the years. You do bring up an interesting point, what do you do with the dropout.

I suppose with all the inefficiencies that we have, in our world today, that that might be one that we would have to swallow. I cannot think of any answer. But I appreciate your comment.

I would like to add, Mr. Chairman, if I could, I notice Mr. McNulty is in the audience, if he would be willing to respond for the Georgetown Medical School for those same figures? I think it would be a good figure to have in the record and I would appreciate it.

Mr. MAZZOLI. Does Counsel have any questions?

HOWARD UNIVERSITY

Mr. HOGAN. Yes. Do you happen to know what the tuition is at Howard University?

Dr. FEFFER. \$800 strikes me as a figure I recall—I do not know whether that was last year or this year.

Mr. HOGAN. The Federal Government contributes about 55 percent of the operating expenses and something in the neighborhood of 85 percent of the capital funding? Is that not about right?

Dr. FEFFER. We heard this, and we also heard that the operating expense of the dollar amount is in the amount of \$6 million.

GRADUATES

Mr. HOGAN. I think the Georgetown representatives indicated that by and large they view this as a nationally unique situation, but that from their statistics as I recall it, there are 16 percent of the graduates of Howard University remaining in practice in the District of Columbia and you have 14 percent and Georgetown 11. Is that it?

Dr. ELLIOTT. Yes.

Mr. HOGAN. Then historically, as I see it, the District of Columbia as a government has not contributed to either Georgetown or George Washington or Howard University?

Dr. ELLIOTT. No, sir. This would be correct.

DISTRICT OF COLUMBIA CONTRACTS

We have contacts with the District government to provide services of various kinds.

Mr. HOGAN. This is for indigent care and things like that?

Dr. ELLIOTT. Yes.

Mr. HOGAN. I think you even indicated there that your reimbursement is \$38—and what is the cost?

Dr. FEFFER. We do not get anything for nothing from the District of Columbia government.

Mr. HOGAN. You get reimbursed \$38 a day?

Dr. FEFFER. For hospital care, and \$6 ambulatory visit which includes all the laboratory work, X-rays, and everything that is done at the time of the particular visit.

Mr. HOGAN. I gather historically also that the District government has never had to pay for or fund the undergraduate medical program by and large except with the recent funding of the Federal City College?

In other words, the District government never contributed to any tuition, scholarships or anything else, for indigent students at your institution did they?

Dr. ELLIOTT. No, sir.

Mr. HOGAN. So up until recently they have not funded, up until the Federal City College, any medical colleges?

Dr. ELLIOTT. Yes.

Mr. HOGAN. Your contributions have been Federal since, as far as tuition aid is concerned, if you want to call it distress, tuition aid or college directed?

Dr. ELLIOTT. That would be a contribution support grant which made it unnecessary for George Washington, in this case, to raise tuition as high as would have been necessary without it. In that respect, it would be a grant of support from the Federal Government.

STATE PROGRAMS

Mr. HOGAN. Is there any possibility—I know that some areas have regional compacts or agreements, as I understand it, especially on the eastern seaboard—has there been any indication that you would work your way into this so that there would be some possibility of obtaining tuition grants from, say another State, say New York, there you have almost 1,700 graduates practicing in New York that although they take in all students as you indicated, there is certainly no tuition grant for your college.

If a student from New York State goes to New Jersey to medical school, there is no tuition grant from the State of New York is there?

Dr. FEFFER. There is not.

Mr. HOGAN. So the regional concept is they take students from the respective States from whatever region they are in, they just do not charge, they do not look to tuition grants from the particular region where the student comes from, is that it?

Dr. ELLIOTT. Except in certain contractual situations such as Maine and Vermont, Delaware and the University of Pennsylvania.

Dr. FEFFER. North and South Dakota for junior and senior medical students, since they have only 2-year schools.

There are a few isolated instances like that.

Mr. HOGAN. Would you be available if staff wanted you and representatives from HEW, would you be available or have someone there to discuss some of the problems that there seem to be? It may not be a conflict, they may just be enlightenment from their point of view and yours to resolve some of these things as it relates to their statement about intramural services in one area that were not over into some of the other areas where there were deficiencies in this medical practice? Would that be possible, Mr. Chairman?

Mr. MAZZOLI. If the gentleman would yield, I would certainly have no objection—and I do believe that it would be helpful to the committee.

It seems amazing to me that the Director occupying a responsible position of Deputy Under Secretary, to say that, in his judgment, you are all approaching a state of mind where you are going to adopt a program, and you say you adopted the program in 1969: I find that so amazingly disparate. And then Dr. Feffer's statement that he has been in touch directly, and he may be looking at the program and not seen the program, and I really do think we need to get together and see where we stand.

It may not be the whole resolution of the difficulty between HEW and its impression of this bill and bills like it, but I certainly think it is one measure of the dispute, and I would like to see that resolved.

And I would be willing to set up such a meeting.

Dr. ELLIOTT. We shall indeed be available.

Mr. HOGAN. Thank you.

Mr. MAZZOLI. Thank you.

GEORGE WASHINGTON FACILITIES

Doctor, I had one question which maybe it is "crying after spilled milk" type of a question which are always the hardest ones to answer and the easiest ones to ask. In Dr. Feffer's statement and exhibit B which is a summary of actual projected income and expense for the school in line 5 of your expenses, the operation and maintenance of plant and the difference between 1972 and 1973 and 1973-74, is what you testified to as the new building and the increased housekeeping expenses of heating and lighting?

The spilled milk part of my question is how come you got yourself into such an arrangement like that which does not seem to be useful at all except as it adds \$1 million—at least \$1.1 million to your deficit.

Dr. FEFFER. Generosity of our friends, our alumni, and the Federal Government, which not infrequently puts you in this type of a position.

Dr. ELLIOTT. It was a position we asked for because as Dr. Feffer mentioned earlier, we were existing in facilities on H Street which were 50 years out of date, not 10, but were completely inadequate.

Now when you have a chance to build new facilities, of course you want to build adequately for the next 10 or 25 years. We did that. We also built, to increase our student body from 400 to 600. We also built to accommodate the paramedical programs of which we see a great expansion in the next 5 years.

FINANCES

Now we have those facilities. We did not build hastily, expecting heating oil prices to go up to the level that they have in the last 6 months. Just such an item as this, as you know, Mr. Chairman, costs George Washington University this year before July 1, 1974, will cost us between \$300,000 and \$400,000 of unbudgeted funds which we do not have and which we have no way to get and which will put us in a deficit position in June.

Mr. MAZZOLI. As it stands now, we are not really talking about any short-run program, are we, for trying to bail out Georgetown and George Washington? This is going to be an ongoing proposition toward 3 years from now or 4 or 5 years, you or your successors will be in to pretty much ask the same questions?

Is that your view?

Dr. ELLIOTT. Unless and until, the present policy of support for medical education—and I include both public and private schools in that context—the present plan or present policy includes support from Federal, State, and local levels, and local levels come in many forms. Local support comes in many forms.

Until George Washington and Georgetown, it seems to me, are included in all levels of support, we shall be at an unbearable disadvantage in carrying forward a first-rate medical center. And, therefore, keeping pace with the medical education and health services in this country.

What we are asking for, as you have pointed out a number of times, is to fill that gap of State-like support. And, should national policy 5 years from now eliminate that, then presumably national policy would have some other answer to this need.

Mr. MAZZOLI. Doctor, as you look at it now, is the last gap that we have to fill for at least the next 3 or 4 years, this gap that you propose to fill with this bill?

Dr. ELLIOTT. Yes, sir.

Mr. MAZZOLI. You are on all fours, except with those schools like Harvard accepting endowments?

Dr. ELLIOTT. Yes.

Mr. MAZZOLI. You will be able to hack it from then on?

Dr. ELLIOTT. Yes.

DISTRESS FINANCING

Dr. FEFFER. You do understand that this year we are now in, requires distress support? The legislation begins for fiscal 1975, but in direct response to your question, in addition to this legislation, at the beginning of fiscal 1975 we have an application in for distress support. In fiscal 1974, the year we are now in—

Mr. MAZZOLI. That is part of the \$31 million now pending?

Dr. FEFFER. That is right, sir.

Mr. MAZZOLI. Congressman Stark?

STATE PROGRAMS

Mr. STARK. I would like to ask either of you—and I do not mean this to be a parochial type of statement—there are three private medical schools in the State of California. We, in California, give them effectively no aid. We do pay \$12,000 per student, but that is only to create 55 additional slots on top of some 1,200-odd that they are already carrying.

My question is, what is it besides the obvious advantages of the great State of California that are apparent to all, in their process that allows them to go ahead without great, massive infusion? I am not aware that their endowments are so huge.

Dr. FEFFER. I can respond very specifically regarding one of them. Stanford Medical College, which is very, very heavily involved in research, so heavily as you know they are able to spend faculty time and effort to take care of the student educational responsibilities. It is a relatively small operation with the exception of their research capability.

I do not know the answer regarding USC. I am afraid I cannot answer that for you.

Mr. HOGAN. Mr. Chairman?

Mr. MAZZOLI. Mr. Hogan?

Mr. HOGAN. There are 910 graduates of Georgetown and George Washington University that practice in California, so maybe there is

some subsidy from the great District of Columbia that reaches its hand over?

Mr. MAZZOLI. Thank you very much, gentlemen, for your time. We appreciate your help today.

The next group that we have is a panel of the medical and dental associations, Dr. Michael Ball, director, Division of Biomedical Research and Faculty Development of the Association of American Medical Colleges; Prentice Bowsher, director of Division of Federal Liaison, Association of American Medical Colleges; Dr. Clifton R. Gruver, president of the Medical Society of the District of Columbia; and Dr. John Callanan, president of the District of Columbia Dental Society.

Gentlemen, however you arrange yourselves. If you have statements you would like to make, feel free. Anything that you have in the way of a prepared statement will be made a part of the record.

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON
LEGISLATION TO PROVIDE SPECIAL SUPPORT FOR MEDICAL AND DENTAL EDUCATION
PROGRAMS OF PRIVATE SCHOOLS IN THE DISTRICT OF COLUMBIA*

The Association of American Medical Colleges welcomes the opportunity to testify on HR 11108 and related legislation to extend the District of Columbia Medical and Dental Manpower Act of 1970.

Now in its 97th year, the Association 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 114 operational U.S. medical schools and their students, 400 of the major teaching hospitals and 51 learned academic societies, whose members are engaged in medical education and research. The Association and its membership, which includes the medical schools in the District of Columbia, thus have a deep and direct involvement with the legislation the subcommittee is considering.

At the outset, it should be made clear that the Association strongly supports in principle the legislation which the subcommittee is now considering. Such registration would provide critically needed local support for the private medical and dental schools of the District of Columbia.

In this statement, it might be useful, first, to review briefly some of the broader aspects of the financing of medical education in the United States. The entire structure of medical education in the nation is facing difficult and threatening financial problems. In fact, all of higher education in the nation is confronted with grave financial difficulties. The problems of medical education are particularly acute. Medical education has always been the highest cost element of higher education because of the integral laboratory and clinical care activities involved. These high costs have now been compounded by the price-wage inflationary spiral which has been advancing at the rate of upwards of 6 percent per year.

In addition, the rapid advance of science and technology has changed profoundly the character of medical education, as it has medical care and health services. The medical sciences have become increasingly complex and the process of diagnosis and therapy now encompasses a vast array of technical services, powerful drugs, and new, increasingly complicated techniques. As these changes have added to the cost of medical care, by the same token they have added to the costs of medical education.

Furthermore, medical education now embraces a wide range of tasks and responsibilities. Once confined to the limited task of educating the M.D., it now encompasses major research programs, graduate education in both the basic and clinical sciences, and a growing responsibility for patient care and community service. This process of growth has been accompanied by extensive changes in the basic financial support base for these institutions. For the better part of the post-war period, national concern with the solution of major disease problems resulted in federal support flowing to the institutions providing medi-

*Presented by the Association of American Medical Colleges before the Subcommittee on Labor, Social Services, and the International Community of the House District of Columbia Committee, January 24, 1974.

cal education for the single function of research. This increase in federal research support took place at a time when the role formerly played by foundations, private support sources, and other philanthropy in supporting medical education was diminishing.

At the same time, the medical schools were being asked to expand their educational functions in the production of M.D.s and other health professionals and to extend their capabilities in the community health scene. In recent years, because of general budgetary pressures, national efforts to control inflation, and shifting priorities on the national scene, there has been a substantial turn-down in the flow of federal research funds to medical schools. Although federal programs were initiated to expand the production of physicians, these new programs have only recently begun to deal with the underlying instability of the financial base of American medical education. This is the set of problems which today confronts the entire medical community.

These trends have had their earliest and most serious impact upon private medical schools because of their crucial dependence upon operating income and endowment earnings. Many of these schools, as a result, have been brought to the very brink of financial disaster. The repeated deficits that they have faced have, in many instances, forced the use of endowment capital to cover operating costs. The prospect of substantial cutbacks in these medical educational programs has resulted in substantial concern on the part of many state governments for the private institutions within their boundaries.

All states are aware of the valuable asset that an academic medical center constitutes in the community and the state in which it is located.

First and foremost, it offers the opportunity for medical education to aspiring students, and thus expands the critically short pool of physicians available for medical care.

Secondly, the academic medical center exerts an important and pervasive qualitative influence upon the whole of the medical practice and health service scene in the areas contiguous to the community in which it is located. It serves as a valuable referral center for specialized services; it educational training programs, including continuing education, assert a widespread influence on the numbers and quality of medical care personnel; and its research programs assist in solving important health problems, as well as serving as an important economic asset.

As a consequence of the state governments' concern with the financial condition of their private medical schools, an increasing number of states have enacted some form of direct state assistance to the private medical schools within their boundaries. The data in the attached tables, prepared by the Association of American Medical Colleges, show the extent to which states are supporting the private medical schools. Fourteen of the 21 states with private medical schools provide some form of state aid to the private schools.

These developing state arrangements have been reviewed briefly to convey to the subcommittee the growing recognition on the part of the states of the importance of preserving and advancing the stability and programs of their private medical educational institutions as an asset of considerable worth to the state and its citizens.

The Comprehensive Health Manpower Training Act of 1971 (PL 92-157) provides certain institutional support for the regular operating budgets of the medical schools. However, the capitation support furnished under the Act is predicated on substantial resources from the state and private sectors. The amounts provided under the Act cover only about one tenth the estimated cost of educating a medical student. Thus, the 1971 legislation does not diminish the need for continuing support of the private medical and dental schools by the District of Columbia.

The Congress of the United States, particularly the District Committee of the House of Representatives, stands *in loco parentis*, as the state legislature, to the District in its position as a governmental unit comparable to a state. The Association urges that in this role the Congress provide additional support above that provided through national programs for the nation's medical schools for the critically important medical and dental educational institutions in the District of Columbia.

In the past the District's private medical schools have in practice received special relief from funds appropriated to meet the financial distress of all the medical schools across the country after other sources available to the schools, including state assistance, have been exhausted. The District's schools, to be sure, should have equal access to the national pool of financial distress funds.

It is the Association's strong belief, however, that funds provided to the District's schools in Congress' role as a state legislature for the District should be provided as a separate line-item in the regular Labor-HEW appropriations legislation. Such an appropriations process seems to be the only equitable method for Congress to supplement, as so many states do for their schools, the national sources of financial support available to the District's medical and dental schools.

To achieve the Association's objectives, it recommends that the pending legislation be modified to require that funds appropriated under the District of Columbia Medical and Dental Manpower Act of 1970 be appropriated for the District of Columbia through the annual Departments of Labor and Health, Education and Welfare appropriations legislation. The Association also recommends that the receipt of such funds by the District's private medical and dental schools through the Labor-HEW appropriations measure shall in no way affect the eligibility of the District's schools to seek financial distress assistance under section 773 of the Public Health Service Act. The intent of the Association's recommendations is (1) to clearly separate that portion of the Congressionally provided assistance to the District's private medical and dental schools which Congress is providing in its role as a state legislature for the District of Columbia; and (2) to preserve the District schools' access, if necessary, to nationally available funds to relieve the financial distress of health professions schools.

[From the Journal of Medical Education, October 1973]

STATE ROLES IN FINANCING MEDICAL EDUCATION

State legislatures in fiscal 1972 provided a total of about \$334.2 million for the operation of medical schools, exclusive of funds to schools in development and to teaching hospitals. Of this total, \$303.2 million went to 63 public medical schools located in the states providing the funds; \$1 million was made available through regional compacts to public medical schools located outside the states providing the funds. Private medical schools received approximately \$30 million from state governments—\$29.4 million in direct payments and \$0.6 million through regional compacts. Additionally, public and private medical schools received approximately \$1.8 million from city and county governments.

The level of funding provided by each state is presented in Table 1. These figures exclude funds channeled through regional compacts. On a total funding basis, state appropriations ranged from a high of over \$36 million for New York to a low of \$765,000 for South Dakota. Table 1 also lists the state appropriation per capita and the state appropriation per \$1,000 of personal income. In fiscal 1972 there was considerable variation in state expenditures for medical school operations relative to population and personal income. Missouri spent 99 cents per capita while 11 states spent over \$2 per capita. One state, Arizona, spent \$3.57 per capita for medical school operations. Based upon the state appropriation per \$1,000 personal income, the figures ranged from a low of \$0.21 per \$1,000 personal income for Minnesota to a high of \$0.76 for Arizona. Ten states spent over 50 cents per \$1,000 personal income for medical school operations.

SUPPORT OF PRIVATE MEDICAL SCHOOLS

State legislatures have been limited by institutional and legislative prohibitions in awarding state funds to private institutions. In recent years, however, pressures to increase the supply of physicians have led a number of states to offer support to private medical schools. The following is a summary of fiscal 1973 state and District of Columbia programs for the support of private medical schools:

California—The state contracts with its private medical schools to expand class sizes. In fiscal 1973 it appropriated \$660,000 to provide for 55 additional students at a rate of \$12,000 per student. This award was not contingent on the residency of students.

District of Columbia—In fiscal years 1971 and 1972 awards were made to the private medical schools—Georgetown and George Washington—not under the special legislation authorizing such support but under the Department of Health, Education, and Welfare's special project grants program to alleviate financial distress. Similar awards were made for fiscal year 1973.

Delaware—The state contracts with an out-of-state college of medicine to accept up to 20 Delaware residents per year. A provision stipulates that a "portion" of the Medical students spend their clinical clerkships in the Wilmington Medical Center. The state of Delaware pays \$7,500 per student to the private medical school, with an arrangement that guarantees a minimum annual payment of \$120,000.

Florida—In 1952, Florida enacted legislation to provide support to the first accredited medical school in the state, which happened to be a private institution. Continuing legislation was passed to provide \$6,500 per Florida student for those completing their education in four years (or \$8,500 per Florida student for those completing their education in less than four years) in fiscal 1973. Use of these funds is limited to operating purposes.

Illinois—In the spring of 1969, the Illinois General Assembly enacted the Health Services Education Grants Act providing funds to private institutions for increasing enrollments in medical, dental, nursing, and allied health education programs.

TABLE 1.—STATE APPROPRIATIONS FOR PUBLIC AND PRIVATE MEDICAL SCHOOLS, FISCAL YEAR 1972¹

State	State appropriation (thousands)	Private school component of state appropriation (thousands)	State appropriation per capita	State appropriation per \$1,000 personal income
Alabama	\$6,086		\$1.77	\$0.52
Arizona	6,317		3.57	.76
Arkansas	2,395		1.25	.36
California	32,109		1.61	.31
Colorado	4,365		1.98	.42
Connecticut	4,085		1.35	.25
Florida	7,438	\$2,780	1.10	.25
Georgia	7,623		1.66	.42
Hawaii	1,070		1.39	.27
Illinois	13,656	3,539	1.23	.24
Indiana	10,187		1.96	.44
Iowa	8,667		2.86	.65
Kansas	4,864		2.16	.47
Kentucky	5,284		1.64	.45
Louisiana	4,293		1.18	.33
Maryland	5,386	800	1.37	.27
Michigan	20,283		2.29	.46
Minnesota	4,197	32	1.10	.21
Mississippi	3,349		1.51	.48
Missouri	4,622		.99	.23
Nebraska	3,504		2.26	.53
New Jersey	12,526		1.75	.33
New Mexico	2,182		2.15	.56
New York	36,105	8,614	1.98	.37
North Carolina	8,632	477	1.70	.45
North Dakota	795		1.29	.34
Ohio	16,921	2,250	1.59	.35
Oklahoma	3,779		1.48	.38
Oregon	5,544		1.63	.59
Pennsylvania	20,822	6,765	1.77	.39
South Carolina	5,243		2.02	.57
South Dakota	765		1.15	.30
Tennessee	4,143		1.06	.28
Texas	30,556	2,083	2.73	.65
Utah	2,473		2.34	.59
Virginia	6,995		1.50	.35
Washington	7,028		2.06	.46
West Virginia	3,781		2.17	.59
Wisconsin	5,141		1.16	.27
Total	332,610	29,416		

¹ The data relate to funds provided directly by the State to fully operational medical schools located within the State and to State-related schools in Pennsylvania. They exclude funds provided to medical schools through regional compacts. Data are not available for direct State support provided to the medical schools located in Puerto Rico and Vermont. The 1972 State appropriations are derived from the 1972 Liaison Committee on Medical Education Annual Medical School Questionnaire. Data for Indiana and Kansas universities are based on estimates from the 1971 LCME questionnaire. Population data for the "State Appropriation per Capital" calculation are for 1970 and are taken from the "Statistical Abstract of the United States," 1972, 93d annual edition, p. 12. Personal income data for the calculations in the last column are based upon preliminary 1972 figures from the "Survey of Current Business," April 1973, vol. 53, No. 4, p. 17.

Each school is allowed \$6,000 annually for each additional Illinois resident which it enrolls, with the requirement that at least 20 additional Illinois residents be enrolled in each entering class over the average number of Illinois students enrolled per class for the years 1964 to 1967.

In addition, an annual stabilization grant of \$1,000 per student, based on the number of Illinois resident students enrolled in the year 1967, is to be awarded. This grant was contingent upon a commitment by the school to the minimum expansion of 20 Illinois resident students in fiscal 1968.

A single, nonrecurring program expansion grant was made for each of the private medical schools for planning and capital construction, attendant upon increasing this enrollment. No grants were given for any expansion of less than 20 Illinois resident students, and grants to schools that expanded beyond 20 additional students were based on the projected size of the additional increment. Fifty thousand dollars was awarded for each of the first additional 20 Illinois resident students. Beyond this initial grant for each additional Illinois resident, \$20,000 is awarded each year for each enrollee projected above the initial increment of 20 such students.

Maryland—The state's private medical school received \$800,000 per year on an emergency basis in fiscal 1972 and 1973.

Minnesota—Legislation was passed for the 1973 fiscal year awarding \$8,000 per Minnesota resident.

New York—The state university system has three types of contractual arrangements with each private medical school in the state—(a) the Bundy Plan, providing \$2,400 for each medical school graduate; (b) a per capita award of \$1,500 for every medical student enrolled; and (c) a seven-year plan designed to increase enrollment during the period from 1967–68 through 1973–74. In the seven-year plan the average enrollment for each class of medical students enrolled from July 1961 through June 30, 1966, was computed as the base; \$6,000 is paid for each additional student enrolled over the base period average.

An individual student may be counted only once for all of these programs through his first three years. However, both the \$1,500 grant and the \$2,400 grant may be awarded in the fourth year.

North Carolina—This state's contract medical program with its private schools of medicine provides a per capita grant of \$3,000 for each North Carolina resident enrolled. Five hundred dollars of this \$3,000 per capita awarded is held in a special scholarship fund to provide financial assistance to deserving North Carolinians enrolled. The only restriction is that the sum must be utilized so as to be highly beneficial to the overall welfare of the state of North Carolina.

Ohio—This state has a contract medical program whereby the private university agreed to admit and maintain not less than 110 first-year students in fiscal 1972 and to admit 125 first-year students in fiscal 1973. A subsidy payment of \$4.5 million was paid to the university for the biennium 1971–73. The subsidy was not contingent upon the residency of the students.

TABLE 2.—REGIONAL EDUCATION PROGRAMS IN MEDICINE FISCAL 1973

Program	Participating States	Contracting institution		Number of students		Total funds to	
		Public	Private	In program	Per capita award	Public schools	Private schools
New England Board of Higher Education.	Maine, Massachusetts, and Rhode Island.	1	-----	159	† \$5,000	\$720,000	-----
Southern Regional Educational Board.	Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Tennessee, and Virginia.	-----	1	110	3,250	-----	\$357,500
Western Interstate Commission for Higher Education.	Alaska, Arizona, Hawaii, Idaho, Montana, Nevada, and Wyoming.	13	3	246	3,000	656,000	82,000
Total	-----	-----	-----	515	-----	1,376,000	439,500

† \$2,500 each for 30 students who are Maine residents.

Pennsylvania—The amount of the awards measured on a per capita basis for fiscal year 1972 were as follows: (a) \$7,465 per capita to three state-related schools and (b) \$4,400 per capita to four state-aided schools. There was no change for fiscal year 1973. These awards are not contingent upon the students' state of residency.

One of the major characteristics that differentiates "state-related" from "state-aided" schools is the university board of trustees. The state appoints a certain

number or members to the board of trustees of a "state-related" university, thereby giving the state a direct hand in making policy decisions that govern the operations of the institution.

Rhode Island—The state's private medical school received a \$200,000 grant from the state for fiscal 1973, with no restrictions placed upon the use of the funds.

Tennessee—The state appropriated \$40,000 for support of its private medical schools for the 1973 fiscal year. This amount was divided between the state's private schools on a formula basis reflecting the increase in the number of Tennessee residents who enrolled in each school over an established base.

Texas—The Texas legislature appropriated close to \$2.1 million in fiscal 1972 for that state's private medical school. That figure has doubled to \$5 million for fiscal 1973. This represents a change of from \$14,370 per private student for fiscal 1972 to \$17,282 for fiscal year 1973.

Funds are channeled through a coordinating board which contracts directly with the private medical school. The support to the private medical school, during each scholastic year, equals the average annual state tax support per undergraduate medical student at the established public medical schools multiplied by the number of Texas undergraduate students at the private medical school.

Wisconsin—The state has appropriated funds on a biennial basis for medical education in its private medical school since 1969. The amount appropriated during the 1971-73 biennium was \$3.7 million. No restriction on the use of the award was made, nor was the grant contingent upon increased enrollment or the residency of an enrolled student.

REGIONAL CONTRACTS

The three regional boards—New England Board of Higher Education, Southern Regional Education Board, and the Western Interstate Commission for Higher Education—have a combined total of 18 contracts with accredited public and private institutions. Funds flowing through the boards for contract programs in medicine totaled nearly \$1.6 million for fiscal 1972. Nearly \$1.8 million was made available for fiscal 1973 (Table 2).

ROBERT CAROW,

AAMC Division of Operational Studies, Washington, D.C.

STATEMENT OF DR. MICHAEL BALL, DIRECTOR, DIVISION OF BIO-MEDICAL RESEARCH AND FACULTY DEVELOPMENT, DEPARTMENT OF ACADEMIC AFFAIRS, ACCOMPANIED BY PRENTICE BOWSHER, DIRECTOR OF DIVISION OF FEDERAL LIAISON, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. BALL. I would like to give an abbreviated version of my statement.

The Association of American Medical Colleges welcomes the opportunity to testify on the legislation pending before this subcommittee.

At the outset, I should make it clear that the association strongly supports in principle the legislation which the subcommittee is now considering. Such legislation will provide critically needed local support for the private medical and dental schools of the District of Columbia.

FINANCING

In this statement, it might be useful first to review briefly some of the broader aspects of the financing of the medical education in the United States. The entire structure of medical education in this country is facing difficult and threatening financial problems. In fact, all of higher education in the Nation is confronted with grave financial difficulties as has been mentioned earlier in the day.

The problems of medical education are particularly acute. Medical education has always been the highest cost element of higher education because of the integral laboratory and clinical care activities involved.

The rapid advance of science and technology has changed profoundly the character of medical education, as it has medical care and health services. As these changes have added to the cost of medical care, by the same token they have added to the costs of medical education.

Medical education now embraces a wide range of tasks and responsibilities. Once confined to the limited task of educating the physician, it now encompasses major research programs, graduate education in both the basic and clinical sciences, and a growing responsibility for patient care and community service. This process of growth has been accompanied by extensive changes in the basic financial support base for these institutions.

FEDERAL SUPPORT

For the better part of the postwar period, national concern with the solution of major disease problems resulted in Federal support flowing to the institutions providing medical education for the single function of research.

At the same time, the medical schools were being asked to expand their educational functions in the production of physicians and other health professionals and to extend their capabilities in the community health scene. In recent years, because of general budgetary pressures, national efforts to control inflation, and shifting priorities on the national scene, there has been a substantial turndown in the flow of research funds to medical schools.

Although Federal programs were initiated to expand the production of physicians, these new programs have only recently begun to deal with the underlying instability of the financial base of American medical education. This is the set of problems which today confronts the entire medical school community.

These trends have had their earliest and most serious impact upon private medical schools because of their crucial dependence upon operating income and endowment earnings. Many of these schools, as a result, have been brought to the very brink of financial disaster. The repeated deficits that they have faced have, in many instances, forced the use of endowment capital to cover operating costs.

STATE PROGRAMS

The prospect of substantial cutbacks in these private medical educational programs has resulted in substantial concern on the part of many State governments for the private institutions within their boundaries.

All States are aware of the valuable asset that an academic medical center constitutes in the community and the State in which it is located.

First and foremost, it offers the opportunity for medical education to aspiring students, and thus expands the critically short pool of physicians available for medical care.

Secondly, the academic medical center exerts an important and pervasive qualitative influence upon the whole of the medical practice and

health service scene in the areas contiguous to the community in which it is located.

As a consequence of the State government's concern with the financial condition of their private medical schools, an increasing number of States have enacted some form of direct State assistance to the private medical schools within their boundaries. The data in the attached tables, prepared by the Association of American Medical Colleges, show the extent to which States are supporting the private medical schools; 14 of the 21 States with private medical schools provide some form of State aid to the private schools.

These developing State arrangements have been reviewed briefly to convey to the subcommittee the growing recognition on the part of the States of the importance of preserving and advancing the stability and programs of their private medical educational institutions as an asset of considerable worth to the State and its citizens.

HEALTH MANPOWER TRAINING ACT OF 1971

The Comprehensive Health Manpower Training Act of 1971, Public Law 92-157, provides certain institutional support for the regular operating budgets of the medical schools. However, the capitation support furnished under the act is predicated on substantial resources from the State and private sectors. The amounts provided under the act cover only about one-tenth the estimated cost of educating a medical student. Thus, the 1971 legislation does not diminish the need for continuing support of the private medical and dental schools by the District of Columbia.

JURISDICTIONAL QUESTION

The Congress of the United States, particularly the District Committee of the House of Representatives, stands in loco parentis, as the State legislature, to the District in its position as a governmental unit comparable to a State. The association urges that, in this role, the Congress provide additional support above that provided through national programs for the Nation's medical schools for the critically important medical and dental educational institutions in the District of Columbia.

In the past, the District's private medical schools have in practice received special relief from funds appropriated to meet the financial distress of all the medical schools across the country after other sources available to the schools, including State assistance, have been exhausted.

The District's schools, to be sure, should have equal access to the national pool of financial distress funds. It is the association's strong belief, however, that funds provided to the District's schools in Congress' role as a State legislature for the District should be provided as a separate line-item in the regular Labor-HEW appropriations legislation. Such an appropriations process seems to be the only equitable method for Congress to supplement—as so many States do for their schools—the national sources of financial support available to the District's medical and dental schools.

AMENDMENTS PROPOSED

To achieve the association's objectives, it recommends that the pending legislation be modified to require the funds appropriated under the District of Columbia Medical and Dental Manpower Act of 1970 be appropriated for the District of Columbia through the annual Departments of Labor, and Health, Education, and Welfare appropriations legislation.

The association also recommends that the receipt of such funds by the District's private medical and dental schools through the Labor-HEW appropriations measure shall in no way affect the eligibility of the District's schools to seek financial distress assistance under section 773 of the Public Health Service Act.

The intent of the association's recommendations is (1) to clearly separate that portion of the congressionally provided assistance to the District's private medical and dental schools which Congress is providing in its role as a State legislature for the District of Columbia; and (2) to preserve the District schools' access, if necessary, to nationally available funds to relieve the financial distress of health professions schools.

Mr. MAZZOLI. Thank you very much, Dr. Ball.

Mr. Bowsheer?

Mr. BOWSHER. I do not have any additional comments to make at this time.

Mr. MAZZOLI. Dr. Gruver?

Dr. GRUVER. You have a copy of our statement.

Mr. MAZZOLI. That will be accepted in the record.

[The prepared statement of Dr. Gruver follows:]

STATEMENT OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

Mr. Chairman and members of the committee, I am Dr. Clifton R. Gruver, a physician in the practice of Internal Medicine in Washington, D.C., for over twenty years. I appear today as President of the Medical Society of the District of Columbia, the only state society ever chartered by Congress, and a society which has a membership of 3,000 physicians who practice in this metropolitan area.

I shall not dwell at any great length on the reasons why this bill should be passed. I believe these to be well-documented from testimony which has been given in years past, and that which will be given here today. However, I would emphasize that the medical manpower needs of the District of Columbia are supplied in great measure by the Georgetown and George Washington University Schools of Medicine. Combined, these two schools graduate approximately 350 physicians each year. Over 30 percent of these physicians choose to stay in this community for their continued education, and subsequently remain here to enter into practice. Statistics show that at the present time approximately 1,000 graduates of each of these schools of medicine are practicing in this area.

We believe that the financial plight of private medical schools in this country is also well-documented. You have heard in testimony that income from tuition and other sources is not sufficient to support the cost of a four-year medical education. It would, therefore, be a real catastrophe for medical education, especially in this nation's Capitol, if these schools were once again forced to consider closing their doors because of the lack of funds. To lose this great source of physician manpower, would have a serious effect on the high ratio of physicians which this city enjoys. And, their services are essential to the delivery of good health care to the citizens of this community.

In compliance with previous national legislation, both of these schools have made tremendous progress in increasing the size of their student bodies and the number of physicians graduated each year. In keeping with this increased effort, we recognize the strenuous effort which both schools have made, in the past and

present, to find new sources of private funds to support ever-increasing costs. In spite of these efforts, however, as we have heard, they find themselves unable to continue without the assistance which this bill will provide.

In closing, I reiterate that The Medical Society of the District of Columbia strongly supports the passage of this bill so as to make it possible for the private, nonprofit medical schools of this city to continue their great work.

Thank you for the opportunity and the privilege to present our views.

STATEMENT OF DR. CLIFTON R. GRUVER, PRESIDENT, MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

Dr. GRUVER. You know from our statement that we wholeheartedly endorse an extension of legislation for these two medical schools, and I would like to point out, too, it occurred to me this morning as I listened to the testimony that regardless of how many of these graduates stay in the area to practice, if we close the door on these medical schools, we are not going to have anybody staying and practice. We are not going to be producing physicians that now have a locality in which to stay.

HEALTH TRAINING PROGRAMS

You have to remember that there is an additional area of manpower that comes from the medical schools in the form of their health graduate training programs, and there is a significant pool of health training schools. A significant number of the people who are trained in the training schools of George Washington and Georgetown remain in this community to practice medicine.

Mr. MAZZOLI. Remain here to practice?

Dr. GRUVER. Remain in this community to practice.

I think it is good to emphasize the point as to George Washington as to their new school of physicians' assistants is concerned. If we are concerned about the health manpower situation and what to do about the inner city, this is one aspect that has to be developed in our medical society. We are certainly scrutinizing this aspect.

These schools, also, through the excellence of their faculties, provide superb facilities for continuing education for the professional citizens of this city, and are actively participating in graduate training programs, continuing education programs for our membership.

I think the point should be made that they are doing continued research programs, and these research programs have had advancements in renal disease, hypertension, as we heard earlier. These are benefits, not only nationally but benefit to our local residents, too, since they have entrance to the higher echelon of care that needs these kinds of superb skills and facilities.

FACULTIES

Their faculty, also, has become much more conversant with the privately practicing sector of medicine, and instead of there being a divergent path between the university and academia, and the privately practicing sector, they are converging, that in expediting the development of their departments of community health they are encouraging young physicians to seek careers in family practice, primary care, and I think they really are beginning to have a major impact on community health needs by these types of developments.

COMMUNITY SERVICES

They are also active, the faculties of these schools, the deans and the academic vice presidents, with our medical society, under the umbrella of our medical society with some health planning councils that have been formed. The council that meets on a monthly basis that comprises representatives of the universities, of the practicing sector of medicine, of the Department of Human Resources, of the community hospitals, meeting and having dialog and communication on a monthly basis about the health needs of this particular community, ambulatory medical care being one of the major subcommittee thrusts.

They are also actively participating in a medical society we have a medical society of 3,000 physicians, 2,000 active members, 50 active committees, 1,000 doctors who are participating on a monthly basis of committee activity that deals not only with professional aspects, professional welfare, but community aspects of mental health, drug problems, alcoholism, community health projects planning and so forth, and their faculty of these schools are members of the medical society for great part, and they are actively participating in input in it.

So I wanted to make these few points on a different slant, and perhaps the value of the presence of these medical schools may be not just for the purpose of graduating young physicians, of doctors with medical degrees, but how they have an ongoing active participation locally for our professional health needs.

Mr. MAZZOLI. Dr. Gruver, one quick question.

As a practicing physician, even though you may be on a leave of absence now as a physician, being president of the society and having been before enough of these congressional committees, do you find as a practitioner it useful to have hospitals and teaching facilities in your area, both because I guess it gives you a better resource facility for the tough cases as well as it adds to the quality of the practice and it adds to the ability to be able to render a good, complete medical service?

Is that a fair statement?

Dr. GRUVER. That is a fair statement. That is certainly one very definite service that they provide.

Mr. MAZZOLI. The closedown of these schools certainly is not going to happen if we can prevent it. If that event were to occur, would it be a detriment to the whole medical practice, to the whole medical situation in this community, in this whole area?

Dr. GRUVER. Unquestionably.

Mr. MAZZOLI. Dr. Callanan.

STATEMENT OF JOHN CALLAHAN, D.D.S., PRESIDENT, DISTRICT OF COLUMBIA DENTAL SOCIETY

Dr. CALLANAN. I would like to take one sentence out of my prepared statement that I would like to emphasize.

GRADUATES

We keep hearing about how many residents of the District of Columbia go to a school and how many graduates of a school stay in the District of Columbia. Fifty percent of the practicing dentists in the Washington area are alumni of Georgetown Dentistry. That is the Washington area. It is not the District of Columbia.

Two cases in point. By virtue of my parents buying a house half a block on the other side of Western Avenue, I was a Maryland resident, but I went to Georgetown. I have practiced here in the city. A great number of my classmates were boys from Connecticut, Rhode Island, Massachusetts, and New York. When they come to Washington they intended to become dentists and then go back to their States. Four years at that particular time in their life, they had met girls here, they had made friends here, they are still here.

These schools attract to your city permanent residents, and I think this is the problem that the gentleman was saying that the State of Maine is sending the kids to the University of Vermont and they are not coming back to Maine. You cannot very well overestimate the effect of those 4 or 6 years of a person's life.

Another point that keeps coming up, I do not think it makes much difference how many of the citizens of the District of Columbia we take in. It is how many physicians you produce in the District of Columbia. I do not care where they came from. That is the name of the game, producing the physicians.

One point that was not made, they talk about the difficulty of getting people to practice in the ghetto. I think possibly with this thrust of the Federal Government to provide funds for the poor people so that they can afford medical and dental care, this is why you cannot get anybody to practice. They cannot make a living there. Give these people the funds to pay for these and I think this problem will begin to solve itself.

The fact that it is not a particularly nice place to conduct a business, you are not going to help that except by doing away with the ghetto.

I would also like to file a statement from the American Dental Association.

Mr. MAZZOLI. That will be done.

Without objection, your statement and those of your association will be part of the record.

[The statements referred to follow:]

PREPARED STATEMENT OF DR. JOHN H. CALLANAN, PRESIDENT, DISTRICT OF COLUMBIA DENTAL SOCIETY

Mr. Chairman and members of the committee, I am Dr. John H. Callanan, President of the District of Columbia Dental Society.

The dental manpower needs of the District of Columbia is supplied in a large measure by Georgetown University, School of Dentistry. Fifty percent of the practicing dentists in the Washington Metropolitan Area are alumni of this school.

It would be a catastrophe to dentistry in this locality if this school was forced to close because of a lack of funds. The services provided by this school are essential to the delivery of good dental health care for our citizens. This is a time when dental care must be expanded rather than curtailed and the number of available dentists must be increased.

We note the great efforts that Georgetown University has made to increase private funding and control operating costs. The District of Columbia Dental Society supports H.R. 11108 and requests your approval of this urgently needed financial assistance for this private, non-profit school of dentistry.

Mr. Chairman, in addition, I would like permission to file for the record a statement from the American Dental Association supporting these bills.

Thank you for the opportunity to appear before this committee.

MEDICAL ASSOCIATION'S RECOMMENDATIONS

Mr. MAZZOLI. To clear the record, Dr. Ball, I received—and you are well aware of the problem—I received two letters, one November the 5th, one November the 12th, one saying that your group was very strongly in favor of a funding system wherein the two schools would go through the District of Columbia Appropriations Subcommittee. On November the 12th, following the time-honored diplomatic tradition, another letter came out without any reference to the earlier letter, with an entirely different approach toward funding that endorses this attitude of going through the Labor-HEW Subcommittee.

Just for the sake of clearing up the record, tell me why Dr. Cooper had this change of heart and what produced this 180° turn in the road?

Dr. BALL. I would like Mr. Bowsher to answer the question.

Mr. BOWSHER. I am a little more familiar with some of the maneuvering that went on over these two letters. It may not be any clearer when I am through talking, but at least you will have as much information as we have.

When the initial letter was prepared, we were trying to base our funding approach on something that was on parallel with the funding of Howard University. We were misinformed, and I was simply mistaken in believing that Howard was funded through the District of Columbia appropriations process. In fact, it is not, of course.

When I was informed of this, I very quickly brought Dr. Cooper up to date on the mistake that I had made. He said, Well, fine. Let's continue the same logical process. If you have one private school in the District that is funded one way, it seems logical that if there are other private schools that need similar funding, they would also be funded the same way.

So that is the reason that we subsequently sent you a separate letter proposing—I do not know if I went off on a 180° at least a different view, that just for consistency let's go the HEW-Labor route, but with a separate line item, just as Howard does now, but when we talk about going to the District of Columbia Appropriations Subcommittee or the Labor-HEW Committee, the purpose was the same. We wanted to cut out this State type of support from the national program to support for all 114 schools, including Georgetown and GW, if you follow that.

We were saying, Get your funding through the Labor-HEW bill, but show it as a separate line item that says Georgetown and GW.

Mr. MAZZOLI. The same as it now shows Howard.

Mr. BOWSHER. As it shows Howard as a separate institution.

Mr. MAZZOLI. Your organization represents the medical schools of the country. They show no fear in setting up a precedent like this, that if enough schools have enough political clout and have enough friends on Capitol Hill and get a special line item of setting up some kind of national interest they might have, you are not afraid if that

is a precedent that your own organization would be behind and identify with very strongly?

Mr. BOWSHER. I am not sure that there would be many other schools that would be in a position, if it became a precedent, that could take advantage of it.

Mr. MAZZOLI. I think they could. There is an interesting phenomenon here on Capitol Hill. If you have enough friends, you can find enough pieces of paper and there are enough words to put on those pieces of paper, that they can turn east into west and north into south, and turn a regional school into a national resource pretty fast. But basically, you are not afraid of that happening, because I am convinced that some other schools are going to be making an approach, figuring if GW and Georgetown, are not just doing it, but having your organization work on behalf of the effort, not standing aloof or passive about it and letting the chips fall where they may, but supporting it.

You are not afraid of that?

Mr. BOWSHER. No, sir.

Mr. STARK. Will the chairman yield?

Mr. MAZZOLI. I yield.

Mr. STARK. I wonder if that could be extended, to the Committee on Interior which is soon going to have a request for assistance for a medical school on Guam where they are in the same position as we are in the District, or it could be the Virgin Islands or any other of the territorial possessions. That step would be a beautiful approach, to say we need the same thing. This is what you had in mind. It would not take a very creative fund solicitor for a school in one of those territories to say, ah hah, this works for the District Committee.

That is the kind of worry I have.

Mr. MAZZOLI. Abracadabra, alacazam, and then we have another national medical school. Mark my words, they are going to come knocking on your door. They are going to ask you to write the same kind of letter on their behalf, but they want the November 12 version, not the November 5.

Mr. Gude?

Mr. GUDE. No questions.

Mr. MAZZOLI. Does counsel have any questions?

Mr. HOGAN. No, Mr. Chairman. Thank you.

Mr. STARK. Mr. Chairman.

Mr. MAZZOLI. Mr. Stark.

JURISDICTION QUESTION

Mr. STARK. I would ask this. My feeling is, I would prefer that the decision that we may have to make on this bill be made by an elected District government. They then can make their own determination as to the value of your schools to their community. I am willing to do that now because that is our job. Soon, hopefully we can transfer that. Then, if we did not change what is now the self-determination rule that we had to review their overall budget, we as part of this process could review the decision that the people of the District had made through their elected Representatives. My question is, would any of you see that as an acceptable alternative?

In other words, it would be far better for us, I think, to look at an overall budget for the District, whether or not we have a line item. They would make the decision. If we get into this question of the national interest, then I think this question should go to the Labor and Education Committee.

I would, therefore, favor, if anything, a very short limitation on any funds because I would want it transferred to the city government. I want you to know where my thinking is.

If anybody has a good reason to dissuade me on that, I would love to hear it.

Dr. BALL. The major point of the society's position is, this puts the schools in the District of Columbia in a category that is not competing with the schools in California for the different pot of money. I would not like to see the schools of the District of Columbia competing for the same pot of money.

Mr. STARK. I agree, Doctor.

What I am saying is, if you make that analogy, is it then that the schools should be approaching an elected District government, and the District government should decide how much it wants to aid these private schools, that it should put it in its overall budget which obviously the Federal Government has to contribute to. But we would then be deciding, as I think we should eventually, on the total amount that we are going to ask the Federal taxpayers to contribute to the District, and how much of that medical-dental education you would get in the District would be something that would be decided by the elected Representatives of this district.

If you have no quarrel with that, then I see this as an interim measure until such time as there is a transfer. We are now in a transition, really, of going to a complete self-determination. I gather you would agree. You would be quite willing to plead your case, as it were, before the City Council and elected Mayor as before any of the other committees of Congress.

Dr. BALL. It is up to G. W. to complete its case in this District, but the association as a national body would be consistent with that.

Mr. MAZZOLI. If you would permit me this one observation. That is where your position will rapidly become untenable. That is that the AAMC, if you continue to get involved in individual applications, my fear is that when the Guam situation arises you are going to be compelled to get into that one. Then when the university, another university gets involved, you are taking sides. You are short circuiting some other needy schools I suggest, throughout the country, that might well have not the imaginative approach that maybe these two schools do, or just as much knowledge of political, where the political pressure points are.

This is your own decision. You have made it, and you have made it on behalf of this legislation. It does pose some problems because I tend to agree with the Congressman. What we are talking about here, unless we are talking out of both sides of our mouth, which is not unusual phenomenon on this Hill either, is the fact that we are going to go to the elected board, if there is a consistency here. The only thing that is going to be elected in the near horizon is going to be the City Council of the District of Columbia which becomes in itself the State legislative assembly, so that would have to be something that your group would

probably have to support just as well as they support the application for treating these two schools as national enterprises.

Dr. BALL. The association supports each of the efforts on each of its schools to obtain State funds. I think that is the position we are in relative to these particular schools. I do not particularly want to take sides as it goes via the Labor-HEW appropriations process or the District of Columbia process.

Mr. MAZZOLI. As a further observation, would not your position be more consistent if you had kept your letter of November 5?

Until now you say without an elected city council or State assembly the nearest thing you have to that, first is the authorizing committee, the District of Columbia Committee, next your appropriating committee of the District of Columbia Subcommittee of Appropriations, would that not have been the more logical, consistent approach, keeping with this argument that you are not taking sides? You are simply promoting what is best for private colleges?

Dr. BALL. It depends on the point of view. We thought we had made a mistake in the sense of the fact that what we felt was that these two schools are similar to Howard, and if the Howard situation goes to the Appropriations Committee of the District of Columbia, that is what these schools will want. Subsequently we were told that Howard's budget goes to the Labor-HEW Committee, and we were in the same framework trying to be consistent with our letter of the 5th, and essentially we blew it. We made a mistake.

Mr. MAZZOLI. Counsel, you have a question?

Mr. HOGAN. I would just like to make an observation. It seems historically that the District of Columbia has never supported medical education, except recently, through the Federal City College it did not support through any contribution of their own, whatever that amounts to. It is a premedical, and historically they never contributed to the medical schools. They are getting home rule, and they are faced, I am sure, with a tremendous money crunch and limited resources. It does seem somewhat that you are laying—Congress would be laying on them a dilemma of which the Congress itself finds that if they have to come up with money, are they going to get it out of their own budget or is the Federal payment going to be increased to take care of it, since historically they looked at it as a Federal obligation rather than a local obligation.

Mr. MAZZOLI. That is true. That is what is going to be the adjustment here when, as the City Council takes over the functions of the State assembly as well as an elected City Council, when it starts to juggle these things around.

Nonetheless, thank you, gentlemen.

Dr. GRUVER. Along that line, I wanted to say that with the appropriations limited as they have been, there have been many health projects in the District of Columbia that have had to be cut way back, so that as far as the money for the medical schools being available immediately, it seems that there should be whatever system that can be devised for the appropriation. As to how this should go through, there should be plenty of time for the new kind of statehood to jell.

Mr. MAZZOLI. This is right because there will be some delays and difficulties in getting things under way.

Thank you very much, gentlemen. We appreciate your attendance.

Our last panel, this would be a panel representing the community, and we have Mr. Orren T. Cohill, vice president of the interim advisory board of Northeast Georgetown Medical Center; Ava Wolfe, M.D., member, Steering Committee for Human Rights; Kenneth C. Kennedy, member, Education Committee, D.C. Branch, National Association for the Advancement of Colored People; Vijaya Melnick, Ph. D., assistant professor of biology and premedical adviser, Federal City College.

For the identification of the reporter, you might identify yourselves, however you would like to do it.

Mr. Kennedy, if you would like to get things started?

STATEMENT OF KENNETH C. KENNEDY, MEMBER, EDUCATION COMMITTEE, DISTRICT OF COLUMBIA BRANCH, NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE

Mr. KENNEDY. Thank you, Mr. Chairman, members of the committee, I am Kenneth C. Kennedy, a citizen of the District of Columbia active in over 30 local and national citizens organizations. Today I appear on behalf of the Education Committee of the District of Columbia Branch of the National Association for Advancement of Colored People. I wish to support the need to continue the services of the medical schools at George Washington University and Georgetown University and the dental school at Georgetown University.

COMMUNITY SERVICES

It is essential to have private institutions continue to provide services to the public well-being of citizens of the District of Columbia at the D.C. General Hospital, Children's Hospital, their own hospitals, and other area hospitals. I believe they are very important examples of how the private sector of our community plays a vital role to the public sector.

As I understand it, the funds in this bill are vital to their ability to continue their medical and dental schools which help thousands of D.C. residents and their children each year.

Since the public sector in the District of Columbia does not have the medical and dental manpower to meet the present and continuing health care needs, I believe the funds in this bill must be provided so that they can continue to help the D.C. citizens and the citizens of the metropolitan area.

Mr. Chairman, that is my prepared statement. If you would indulge me for a moment, I would like to add two or three other things for the purpose of the record.

It is my information, Mr. Chairman and members of the committee, that the D.C. General Hospital accommodates approximately 200,000 patients each year. I am advised that Howard University provides doctors and residents, about 10 percent of that number. Georgetown and George Washington Universities accommodate approximately 150,000 of these residents with doctors in residence.

This indeed is a service to the local community and the poor of

that community. I live in the Northeast section of Washington, D.C. In that section recently we had the housing development locally known as Edgewood Terrace. The Georgetown Medical School has a health clinic, and one of my colleagues at the panel certainly will address himself to that later on. We are proud of this contribution by the private sector.

May I further identify myself as a faculty member and as an administrator at Federal City College. While I am not testifying today on behalf of Federal City College, I come with both the knowledge and the blessings of the president of that institution, who works very closely with the consortium of universities in which we work with both George Washington and Georgetown in our cooperative interests.

I may add in that connection, I am currently writing a doctoral dissertation at Virginia Polytechnical Institute and State University, the subject of which is a plan for higher education in the District of Columbia. In reviewing the literature for this work, we come across the Arthur D. Little report, and in that report it specifically recommends that there not be additional medical or dental schools located within the District of Columbia, but that the present facilities of Howard, George Washington, and Georgetown provide the local service and responsibility.

I mention that for the reason that it seems therefore incumbent that we must find a way, as we found in working out home rule legislation, to protect the Federal or the national interest of these institutions and the local interests of which they serve closely. The argument can be made that they can do more. I support that, and I am sure they do.

FUNDING

One final question was mentioned earlier in the day, whether this money should come from national funds or the D.C. Government. Certainly, those of us who are familiar with the fiscal ability of the District of Columbia government today recognize immediately that we do not have the wherewithal to do that. But I look toward the day when we get more self-determination and home rule, and hopefully I am a part of that government, and if I am, I shall be one that will cry out to bring support and find the resources to provide funds for these two institutions to provide that kind of service.

In the meantime, and until that time, I hope that this committee in its wisdom and the Congress in general will find a way to continue to provide these resources. And I recommend that you do it through your committee and the HEW funding for the present time.

And finally, I would like to identify myself with the comments of Congressman Fauntroy with respect to support for the nursing schools at American University and the Washington Hospital Center.

Thank you very much, Mr. Chairman.

Mr. MAZZOLI. Thank you, Mr. Kennedy.

Dr. Wolfe?

Dr. Wolfe, yours is a very lengthy statement.

Would there be a way to summarize it, rather than to read it verbatim?

We will accept your statement for the record.

[The prepared statement of Ava Wolfe, M.D., follows:]

TESTIMONY IN BEHALF OF THE MEDICAL COMMITTEE FOR HUMAN RIGHTS (MCHR)
PRESENTED BY AVA WOLFE, M.D., MEMBER OF THE D.C. CHAPTER'S STEERING
COMMITTEE IN OPPOSITION TO H.R. 1108, THE DISTRICT OF COLUMBIA MEDICAL
AND DENTAL MANPOWER ACT

We would like to present first of all a summary of our testimony, and to follow this with a longer discussion of each point. The *written* testimony is much longer than the *oral* testimony, and includes specific examples of problems cited, and specific positive action programs for this committee and for the two schools in question.

We hope that you will accept this report, not as an MCHR position only, but as a composite of the opinions and suggestions we received over the past two weeks from many *other* groups and individuals *outside* our membership. These sources, and how we solicited their comments, are listed in the addenda.

IN SUMMARY

MCHR's opinion is that as long as George Washington and Georgetown Medical Schools (hereinafter referred to as G.W. and G.T.) continue with "education as usual," we cannot support their getting any funds at all through D.C.

The only kind of bill we could find acceptable would be one that included *all*, not just *some*, of the following features:

(1) It must have *teeth* in it—specific *requirements* of the schools, not just simple "assurances." D.C. students must be actively recruited, and a certain number of slots kept open for them.

Other students receiving funds must provide obligatory service to D.C.'s needy areas for 2 or 3 years after completion of their training.

(2) It must state in writing that this appropriation would in no way reduce the overall city budget, *or* the budget for *training other types* of health manpower than doctors and dentists.

(3) The proposed use of the funds must be subject to approval by the City Council, the Board of Higher Education, and or D.C.'s CHP agency. In addition, the bill must require that a citizen's board be chosen to participate in the administration of any new programs set up with the funds.

(5) Cost control mechanisms must be built in.

(6) Funds per student would not be given as a lump sum to the schools, but would be in the form of scholarships and loan guarantees given *only* to those students enrolled *from* D.C., and those who agree to the obligatory service *in* D.C., and only *after* these students have been signed up by the schools.

(7) Any further funds appropriated must be on the basis of number of indigent D.C. people provided with services, and/or on the basis of number of hours of staff time provided to facilities and services in needy areas. Only in this way could we be sure that D.C. money would be used for D.C. purposes.

(8) The manpower trained must fit D.C.'s *needs*, both with respect to geographic areas and economic brackets where *care* is most needed, and with respect to the *types* of health manpower needed most. If that need is for family physicians, public health nurses, and paraprofessionals, they must provide training for those categories.

(9) The two schools must be required to develop more para-professional training programs for D.C. residents, and upward mobility programs for their school and hospital employees, and to give aid and support to such programs in other parts of the city.

(10) If the amount of funds appropriated represented as sizeable a proportion of the schools' entire budgets as suggested in H.R. 11108, the opportunity must not be passed by to change the methods and emphasis of the educational process itself.

But even if all these provisions are placed in the bill, there are other overriding problems with it. A multi-million dollar program is being pushed over on the D.C. people, not only without their consent, but without their knowledge. It must be the *choice* of the D.C. people whether they want to support a medical school with their tax money at *all*, and *if* so, which one.

Once this bill passes, it will be in effect indefinitely. This is too important an issue to have less than full public consideration. There must be public hearings in several sections of the city, with full publicity in the media, to solicit opinions. Our guess, from the sampling of opinion that we solicited in preparation of this testimony, is that the public's *last* choice would be G.W. *or* G.T.

Now, to enlarge upon each of these points

We grant that the cost of medical education has increased astronomically over the last few years from \$1 or 2,000/student/yr to \$16 to 25,000/student/yr. We are aware of the cuts, not only in federal disaster funds to health science schools, but likely soon in the other major HEW medical manpower bills, and in research and mental health moneys to support faculty. Our chief disappointment is in the reduction of capitation funds that required increasing total student enrollment, and in scholarship funds for poor and minority students. Students are losing federal loans they already had, and are finding it difficult to get guarantees for increased bank loans. Only 800 scholarships are available under the new Public Health Service program, whereas there are 5,000 military scholarships. If other scholarship moneys are not made available, only the rich and military will be able to go to medical school. MCHR is greatly disturbed as it sees this already happening.

On the other hand, we have serious concerns about the request of these two particular medical schools for D.C. funds. To the community, they are the two richest institutions in the city and have no reason to plead poverty. We are told that G.W. University is second only to the federal government in land holdings in D.C., and G.T. University is third in the number of employees. As for the medical schools, G.W. has two large new expensive buildings, and G.T. is planning a multi-million dollar coronary care unit, plus 2 new floors for their Kennedy medical ethics unit. Besides, D.C. is *already* subsidizing them to the extent that their property is tax-exempt.

Also, to the community, these two institutions have little or no basis on which to claim concern for D.C. and its residents. They do little for their own immediate neighborhoods, let alone for the city at large.

They treat too few indigent patients, and essentially segregate them from their private patients in an HMO across the street, and on a second floor general medical ward. They still transfer emergency cases to D.C. General if they cannot pay, despite repeated slaps on the wrist.

They set up services without community input and without seeking consumer representatives for the Board until after the fact.

They *say* they want to listen to the community, but then *refuse* to do the things they request, and *proceed* with doing the things they *reject*.

They made promises they don't keep, and spend a great deal of time and money developing plans for their service areas that never get beyond the blueprint phase.

They show disdain for their D.C. employees and indigent patients alike.

And what convinced D.C. people once and for all of G.W.'s lack of concern both for the community and for meeting D.C.'s health manpower needs, was their announced intent to pull out of D.C. General Hospital—the one place in the city that is *the* most understaffed, and *the* most in need of their aid.

The other prime example of their lack of concern for D.C. residents, and for developing health manpower from among them, was the recent arrests, firings, and suspensions of G.W. hospital workers who wanted a union. One of their main desires was for upward mobility programs and in-service training. Such a program is needed to fill D.C. health manpower needs *far* more than D.C. needs 3 medical schools to produce *doctors*, with a fourth *military* medical school in the offing. But G.W. could not see beyond its own self interest and cost-efficiency when asked to recognize the workers' right to negotiate for such a program.

More specifically with relation to this bill, they have an extremely poor record on D.C. admissions to their medical schools, and on retaining their graduates in D.C. Even the 8% figure they give of graduates staying in D.C. includes those in federal service, research, and suburban practice. This is not satisfactory to the *community*.

CONCERNS

We have the following major concerns about H.R. 11108

(1) It is beyond our comprehension that this bill should presume that these institutions act in good faith toward the community, and that only their "assurances" are necessary. Only if this bill has *teeth* in it in the way of requirements for providing D.C. services, and requirements for producing D.C. health manpower, will they comply. And if they *don't* provide something for D.C., they don't deserve D.C. money.

We are concerned about the appropriation of this money on a per/student basis for the entire enrollment. This also assures almost nothing to D.C. in return for its money. We propose instead, that per/student money should be reserved

only for D.C. students, in the form of scholarships and loan guarantees, which should be larger for poor and minority students and for women who will have child care costs. There should be a timetable with a specified number of slots for D.C. residents, to increase each year. There should also be a requirement for increasing the admissions each year of poor and minority students from elsewhere, and of women. And in lieu of loss of federal funds to encourage increasing total enrollment, that requirement might also be added.

We believe that qualified applicants *can* be found. A number of D.C. students were refused by G.W. and G.T. last year, but were admitted to *other* medical schools around the country and are doing very *well*. A program with high school students could be begun to encourage their interests and to recognize their talents. A summer brush-up semester would prepare those admitted for the transition. And to insure that D.C. residents *admitted* are retained and graduated, tutorial services should be made available.

D.C. residents *don't* have the same right to go to medical school as do residents of states with state schools. If this bill does not *rectify* that situation, there is no justification for D.C. funding at *all*.

We also proposed that if $\frac{1}{4}$ of the operating budgets of these two schools is going to come from these funds, that $\frac{1}{4}$ of the students should either *come* from D.C., or be required to remain and practice in D.C.'s underserved areas for 2 or 3 years after completion of their training. The difference in the number of D.C. admissions and this $\frac{1}{4}$ of the total class, could also have scholarship money and loan guarantees on the basis of promising to fulfill this service obligation. "Forgiveness" clauses in loans would be an inadequate incentive to their staying. And setting up a lucrative suburban practice, or working for the federal government would not qualify.

What remains of the \$6.2 million, should be given to the schools not on a per/student basis, but on the basis of per/D.C. indigent patient cared for, or per hour of staff time provided to health services in underserved areas. This would not only assure that D.C. money would be spent for D.C. purposes, but would also shift the emphasis in medical education for the *entire* student body in the direction of family practice in needy areas.

(2) We are concerned as to whether this will affect the overall D.C. budget.

Your committee has been notorious for cutting the *general* D.C. budget every-time categorical funds are channelled in. Will you cut D.C. budget again *this* time by the amount that is allocated under *this* bill? If so, this bill could be a gross disservice to the community at large, because there are a *number* of D.C. needs that are far more pressing now than the need for more doctors and dentists—such as T.B. and V.D. control, prison health, etc.

More specifically, would the D.C. budget for development of *other* types of health manpower be reduced? In our estimation, there is a far more pressing need here for public health nurses, visiting nurses for the elderly, Spanish nurses and nurses' aides, better technicians, and paraprofessionals, than there is for more doctors and dentists. D.C.'s CHP agency has more specific data on such manpower shortages. This committee has long neglected passing laws regarding paraprofessional licensure, and thus has held up development of training programs for them. It is time that you attended to that problem, and simultaneously state in this bill that it will be funded only if there is full assurance that it will not subtract from the D.C. budget in general or for health manpower programs specifically.

Also, we question whether this would raise D.C. taxes.

(3) We are concerned about the funding *mechanism* suggested in the bill. The request is for funds to be separate and apart from the D.C. budget, which means that it by-passes (a) competition over revenue sharing funds, (b) any review or evaluation of plans and progress by any body of D.C. people. Why can't these institutions work *with* the people of the city instead of setting themselves up independently?

We feel that it is insufficient to have the Secretary of HEW and the Mayor Commissioner to approve the amount appropriated. Perhaps it is justifiable to remove it from revenue sharing competition, but if this is a *D.C.* manpower bill, then people of D.C. should have the final say in how that money will be spent. The institutions should be required to submit their plans to the D.C. CHP agency, the City Council, and/or the Board of Higher Education, not only for their review and comment, but for their approval or rejection. Periodic reports of progress toward the stated goals, and as to the use of the funds, should also be sent to these bodies.

The law should require as well that there be a representative citizens' board set up to work with the schools from the beginning stages of development of all new services and programs with these funds.

(5) We are also concerned about the blanket giving of this large an amount of money to bail out institutions with spiralling costs, without writing in stipulations, or building in incentives, for *cost control*. Hasn't that lesson been learned yet? Perhaps the costs are due to *excesses* that could be *trimmed*.

One of the reasons for the great increase in cost of medical education recently has been the competition between schools, perhaps more acute as in D.C. where several schools are in the same city, for prestige. This is done by unnecessary duplication of highly expensive equipment and facilities especially for the training of subspecialists and research physicians. The training of family physicians, a much more needed type of manpower, costs far less. Probably no factors could reduce the spiralling costs of medical education more than the curtailing of this duplication and emphasis on specialization.

Our immediate thoughts about G.W. and G.T. in this regard, are listed:

(a) More than half the offices and laboratories in the new medical school building at G.W. appear to be empty, yet a grapevine figure of \$1 Mill will be needed yearly just to maintain the building. Either the unused sections should be rented for income, or closed off, or medical students should participate in cleaning up after themselves.

(b) The new coronary care unit at G.T. is designed for 150 beds, when the Intensive care unit at Washington Hospital Center with 75 beds already sits partially empty. This unit is a life-long dream of an excellent physician, but is it really *needed in D.C.*, and should fund-raising for such a subspecialty program that serves only a few take priority over fund-raising for the more basic emergency, out-patient, and preventive care so desperately needed by so many people on the streets of D.C.? Or even priority over getting money for student scholarships? G.T. has already spent a great deal renovating their surgical intensive care unit twice in the last 2 years, the second time because they didn't do it right the first time. Is that not sufficient? Already Washington Hospital Center is turning away indigent cases and closing its nursing school in order to use its money to keep an expensive intensive care unit open. We should not allow this situation to be repeated at G.T.

(6) (Is included in 1.)

(7) We are concerned that the bill does not require the schools to render any services to D.C. What services might we ask for D.C. in return for this bill?

Since this is a D.C. *manpower* bill, the money for services could be on a per/patient basis for indigent D.C. residents *cared for*, and/or on a per/hour basis for manpower provided to health facilities and services that are hurting most because of understaffing, and are most needed to provide comprehensive and preventive services to D.C.'s most needy areas. These would include:

D.C. General—where deaths are still occurring due to understaffing.

Emergency rooms—so that waiting time can be reduced.

Neighborhood health centers—hopefully to provide some *night* hours as well as day.

Community Mental Health Centers—where they need to have a medical doctor as well as psych staffing.

Jails—another high priority need.

New facilities planned East of the River—perhaps G.T. and G.W. could some way help speed up their opening their doors.

No geographic area should get as much emphasis as SouthEast.

Or, the per/hour staffing time could be put into public health efforts such as for specific disease control, transportation services.

One of G.W.'s reasons for leaving D.C. General was IHR's paying them less for doing so. If this bill renewed some funding to them for hours of service to indigent, this might entice them to stay.

Service to the needy in their own HMO's could qualify under this section only:

(a) If they do not take over and replace Neighborhood Health Center.

(b) If they educate the community as to the *disadvantages* as well as the advantages of HMO's.

(c) If they have consumer boards to control the purse strings.

(d) If they will freely return Medicaid cards to patients who are dissatisfied with their services.

The funds for services should not be diverted to administrative and overhead costs, except inasmuch as this represents administration of the D.C. service projects themselves.

Other specific services requested of G.W. in the past which they did not honor were :

- (a) a small low cost pharmacy outlet in Southwest that would stock only more commonly prescribed and generic drugs.
- (b) adult dental services in Southwest.

Services G.W. formerly *promised*, but so far as we know never came through with, were

- (a) transportation services.
- (b) a dispensary in a residential building for senior citizens.

The Spanish need more clinics. G.W. did start a paraprofessional clinic for the Spanish at one time, but the people complained that it was staffed *too* extensively with paraprofessionals, and that they were not getting seen by M.D.'s when they felt they should have been. G.W. did not rectify this, but discontinued the clinic instead.

The Free Clinics have repeatedly asked for volunteer personnel from G.W. and G.T., and one had to close several months ago despite being equipped, because they could not find even one physician from either of these schools or elsewhere.

The elderly want a geriatric rehabilitation hospital to be started in D.C. Patients with particularly problematic cases must be sent to facilities in other states, too far for their families to visit them.

Alcohol treatment centers are needed, not house officers who bodily throw alcoholics out of the emergency rooms.

More V.D. treatment, free of moralizing, is needed.

Dental services that give the poor the benefit of root canal work, etc., rather than just pulling all their teeth because they cannot pay, are needed.

Dental services that don't require repeated visits for work that could have been done in one sitting, are needed.

Citizens' and employee groups want patients' rights materials to be distributed at the hospitals, and advocacy-legal aid services to be set up.

Certainly, to provide *all* of this would be *impossible*, but we would like to see progress made toward providing as many of these services as possible.

Funds already available to the schools for providing services require only that a small percent be utilized for the poor. Under this arrangement, the community considers the services rendered to be only tokenism, not altruism, and provided only at the minimum level required for keeping the grants. Only if the percent given for services is equal to the percent of poor in the total population of D.C., does this cease to be tokenism. Reserving the funds under this bill for services to indigent *only* will help to bring this imbalance at G.W. and G.T. toward a reasonable percentage.

(8) (Already covered)

Another source of funding for medical education is to support research. Research is certainly essential to the progress of medical science and to medical education, but it serves a national purpose and should thus be funded through national channels.

(9) A third source of funds for medical education is for the educational process itself.

Funds for the educational functions of the school, would as we have already pointed out, be in the form of scholarships and loan guarantees to specific students. However, the bill should further require the schools to use this money, once paid to them by the students, in ways that would alter the emphasis and methods of their educational programs for *all* of their students. These could be :

(a) For curriculum innovation, especially to emphasize family practice and community medicine. Students say that family practice and the whole-patient approach are emphasized considerably by certain of the faculty, though they are themselves subspecialists. This is in no way objectionable, but it would help to have some "hero models" around who were true family practitioners.

(b) For salaries of faculty who, rather than producing multiple research papers, are simply excellent teachers; *and* for faculty who will develop paraprofessional training programs for D.C. residents and integrate these with the training of the medical students. They could help to develop new *roles* in the city for paraprofessionals as well—in preventing fire and traffic deaths, etc.

(c) For additional library materials and educational equipment needed to produce these changes.

There should be a change in the relative emphasis between education and services. If education takes precedence, then chiefly the patients with the rare

interesting diseases get the best care, and the student learns good specialty medicine. If service takes precedence over education, then the greatest public needs are given the best attention, and the student learns good general practice and develops a community conscience. Theory and practice then become integrated in the educational process.

If MCHR could design a model medical school, it would have a stepwise training program in which students who go 6 months would be Nurses' Aides, those who go 1 year would be Practical Nurses, for 2 or 3 years an R.N. or Physician's Assistant, and for 4 years a doctor. Students with lesser qualifications could therefore enter the school, and the best students at each level be retained for the next. New medical workers of all types would be produced and fed into the health care system on a steady basis and in numbers according to need and job availability. Every doctor would have gone through all the training for Nurses' Aides, R.N.'s, etc., and would therefore better understand their level of skills and their points of view. With all manpower being trained together in the same classes, they would develop the ability to work together later as teams and with mutual respect.

There are those in D.C. now, connected with the public school's adult education and job training programs, who are interested in developing such a program in D.C. We would like to see G.W. and G.T. funded only inasmuch as they would work, in conjunction with that program, and begin to adjust their own curriculum to fit *into* it once well established. The people of D.C. would be much more likely to want to support a state medical school if it were of this type. As for MCHR, we would prefer to see these special funds go into this *public school* program than into the two medical schools.

Another recent innovation in medical education is the school-without-walls concept. One community group we spoke to said, "Why should G.W. pull out of D.C. General? Why not move the whole school to D.C. General and teach the students on-the-job?" Have the students learn from the real world, from taking real responsibility for meeting a community's health care needs, seeing preventive care work, determining their success or failure on whether they affect a change in the city's health statistics and general state of health, and learning to face their failures as a group dedicated to find new approaches that might work the next time. This would replace the current view of "success" which is making good marks, writing good papers, and eventually making good money and having prestige. This would replace the current incentive to academic competition between students, and get them to see that success depends on group effort. They would at the same time be providing very real services to D.C.

Specific suggestions for service projects that would be appropriate for 1st and 2nd year students follow:

Students we spoke to from both G.W. and G.T. asked for better community medicine programs in the first 2 years of school. This could be done through increasing community service electives, doing more in community medicine than conducting questionnaires, having an exciting department that turns students on to community medicine rather than turning them off. G.T.'s 200 students/class who are falling all over each other in the halls, and G.W.'s 110/class could carry on major public health projects such as:

(a) Screening, referral, and follow-up programs, especially for hypertension, T.B., and lead poisoning.

(b) Reducing infant mortality through seeking out teenage pregnant women and getting food and services to them and to high-risk infants through outreach.

(c) Supplementing the overworked Public Health Nurses in providing outreach for neighborhood health centers and community mental health centers where communication with the community and door-to-door follow-up are so essential.

(d) Carrying out public health education programs concerning communicable diseases, smoking, etc. in schools and waiting rooms.

(e) Providing services to senior citizens, including transportation to clinics, home health aid, getting food stamps, etc.

(f) Training community residents to take over these functions in time; in fact, matching the number of students at least one-to-one with community residents in administering and conducting these functions.

In their 3rd and 4th years, medical students could do more to provide direct patient care within clinic and mental health center settings, not just in hospitals. There must be assurance, however, that they will have adequate supervision, and will respect patients' desires to limit the number of students examining them, etc.

The Out Patient Dept's in the University Hospitals themselves should be restructured so that patients are seen by a consistent student or house officer over a long period of time. Patients are tired of seeking a different student or doctor every time they go to the clinic.

A program similar to one at Western Reserve and Tufts could extend throughout the 4 year program—in which each student is assigned a family to follow for that entire period of time, with increasing responsibilities for the care of that family as the student's level of training increases.

For dental students, preventive dentistry and public health education about dental care could be services provided.

(10) Lastly, our concern is that considering the magnitude of the funds requested, the writers of the bill did not recognize the extent to which this might be used to effect change. If their total budgets for F.Y. '73 were as predicted—8.8 Million for G.W. and 15.1 Million for G.T. (including the dental school)—then the \$6.2 Million maximum requested in this bill represents $\frac{1}{4}$ of their total budgets. This may be a smaller percent than *state* schools get from their *state* governments, but for these two schools it would likely be second only to the federal share of the budget support, and this makes it all the more important to use *this* bill as well as *HEW* bills to bring about controls over their costs, to make demands for services, and to require basic changes in their educational program.

Granted, it would be difficult to comply with all the *specific* suggestions in this testimony, but we feel that the 10 basic concepts presented are not at all too much to expect. There is nothing in the bill as it stands now, however, to indicate that much thought was given to the issues, that any national or local overview was sought in its preparation, or that anyone recognized the great potential for either good or harm that it holds.

There is no current body to provide this national overview of medical schools from outside the self-interest groups, other than the health subcommittees of the House and Senate as they distribute funds. If this committee appropriates this money to the schools, it is the only *other* body (except the military and V.A.) that can write in requirements to bring these schools into conformance with some national scheme. It behooves this committee to work closely with the health subcommittees in determining what that national scheme should be. Stipulations can then be added to the bill to prevent use of the money for inappropriate duplications of training programs for unneeded manpower.

With all due respect to the AAMC, it *is* a self-interest group and as such should not suggest how to police *itself*. Even National Academy of Science suggestions may be heavily weighted since most Institute of Medicine members come from medical school faculty backgrounds.

We want to thank you for inviting MCHR to give testimony. We, like hundreds of thousands of D.C. residents, even those *working* in the area of health, even in conjunction with these medical schools, would have had no idea that this bill was even being considered had you not called us.

We repeat, in closing that public hearings *must* be held. This decision should be in the hands of the people of D.C.

Groups who contributed ideas for this testimony :

One Free Clinic.

South West Community House.

Adams-Morgan residents and health organizers.

Several senior citizen groups, and Gray Panthers, who were attending a meeting on the subject of aging.

The Consumer Requirements and Underserved Areas subcommittee of RMP.

Students from G.W. and G.T. medical schools, and G.T. nursing school.

A premed advisor at Federal City College.

A member of the D.C. Statehood Party.

D.C. Public Interest Research Group which draws students from both G.W. and G.T.

Patients with complaints about hospital services.

Union 1199 at G.W. Hospital.

Announcements were placed in one newspaper and on one radio station to solicit individual comments.

A number of other specific groups and individuals were called by phone.

STATEMENT OF AVA WOLFE, M.D., MEMBER, DISTRICT OF COLUMBIA CHAPTER STEERING COMMITTEE OF THE MEDICAL COMMITTEE FOR HUMAN RIGHTS

Dr. WOLFE. My testimony is in behalf of the Medical Committee for Human Rights, which I will hereafter refer to as MCHR. Our statement is in opposition to H.R. 11108 as written.

We would like to present first of all a summary of our testimony, and to follow this with a longer discussion of each point. The written testimony is much longer than the oral testimony, and includes specific examples of problems cited and specific positive action programs for this committee and for the two schools in question.

We hope that you will accept this report, not as an MCHR position only, but as a composite of the opinions and suggestions we received over the past 2 weeks from many other groups and individuals outside our membership. These sources, and how we solicited their comments, are listed in the addenda.

In summary, MCHR's opinion is that as long as George Washington and Georgetown Medical Schools continue with education as usual, we cannot support their getting any funds at all through the District of Columbia.

AMENDMENT PROPOSED

The only kind of bill we could find acceptable would be the one that included all, not just some, of the following features:

(1) It must have teeth in it, specific requirements of the schools, not just simple assurances. District of Columbia students must be actively recruited, and a certain number of slots kept open for them. Other students receiving funds must provide obligatory service to the District's needy areas for 2 or 3 years after completion of their training.

(2) It must state in writing that this appropriation would in no way reduce the overall city budget or the budget for training other types of health manpower than doctors and dentists.

(3) The proposed use of the funds must be subject to approval by the City Council, the Board of Higher Education, and/or the District of Columbia's CHP agency. In addition, the bill must require that a citizen's board be chosen to participate in the administration of any new programs set up with the funds.

(5) Cost control mechanisms must be built in.

(6) Funds per student would not be given as a lump sum to the schools, but would be in the form of scholarships and loan guarantees given only to those students enrolled from the District of Columbia, and those who agree to the obligatory service in the District of Columbia, and only after these students have been signed up by the schools. Total number receiving these scholarships should be part of the total enrollment, as the school's budget comes from this appropriation.

(7) Any further funds appropriated must be on the basis of number of indigent District of Columbia people provided with services and/or on the basis of number of hours of staff time provided to facilities and services in needy areas. Only in this way could we be sure that District of Columbia money would be used for District of Columbia purposes.

(8) The manpower trained must fit the District of Columbia's needs, both with respect to geographic areas and economic brackets where care is most needed and with respect to the types of health manpower needed most. If that need is for family physicians, public health nurses, and paraprofessionals, they must provide training for those categories.

(9) The two schools must be required to develop more paraprofessional training programs for District of Columbia residents, and upward mobility programs for their school and hospital employees, and to give aid and support to such programs in other parts of the city.

(10) If the amount of funds appropriated represent as sizable a proportion of the schools' entire budgets as suggested in H.R. 11108, the opportunity must not be passed by to use the bill to change the methods and emphasis of the educational process itself.

But even if all these provisions are placed in the bill, there are other overruling problems with it. A multimillion-dollar program is being pushed over on the District of Columbia people, not only without their consent, but without their knowledge. It must be the choice of the District of Columbia people whether they want to support a medical school with their tax money at all; and if so, which one.

Once this bill passes, it will be in effect indefinitely. This is too important an issue to have less than full public consideration. There must be public hearings in several sections of the city, with full publicity in the media, to solicit opinions. Our guess, from the sampling of opinion that we solicited in preparation of this testimony, is that the public's last choice would be G.W. or Georgetown.

Now, to enlarge upon each of these points.

We grant that the cost of medical education has increased astronomically over the last few years. I will not proceed with this part. We know the cuts in the funds. We know students are having to turn to military scholarships because there are not others available.

COMMUNITY SERVICES

On the other hand, we have serious concerns about the request of these two particular medical schools for District of Columbia funds. To the community, they are the two richest institutions in the city, and have no reason to plead poverty. We are told that G.W. University is second only to the Federal Government in land holdings in the District of Columbia, and Georgetown University is third in the number of employees.

As for the medical schools, G.W. has two large, new, expensive buildings, and Georgetown is planning a multimillion-dollar coronary care unit, plus two new floors for their Kennedy medical ethics unit. Besides, the District of Columbia is already subsidizing them to the extent that their property is tax exempt.

The community also sees the new buildings that have also been built, and does not see that they can plead poverty.

Also, to the community, these two institutions have little or no basis on which to claim concern for the District of Columbia and its residents. They do little for their own immediate neighborhoods, let alone for the city at large. We have listed examples.

They show disdain for their District of Columbia employees and indigent patients alike. And what convinced District of Columbia

people once and for all of G.W.'s lack of concern both for the community and for meeting the District of Columbia's health manpower needs, was their announced intent to pull out of D.C. General Hospital, the one place in the city that is the most understaffed and the most in need of their aid.

The other prime example of their lack of concern for District of Columbia residents, and for developing health manpower from among them, was the recent arrests, firing, and suspensions of G.W. hospital workers who wanted a union. One of their main desires was for upward mobility programs and inservice training. Such a program is needed to fill District of Columbia health manpower needs far more than the District of Columbia needs three medical schools to produce doctors, with a fourth military medical school in the offing. But G.W. could not see beyond its own self-interest and cost efficiency when asked to recognize the workers' rights to negotiate for such a program.

STUDENTS

More specifically with relation to this bill, they have an extremely poor record on District of Columbia admissions to their medical schools. This has been brought out. I would like to simply bring out, there is a larger discrepancy than might be apparent between Howard's 16 percent that stay in District of Columbia and the other schools' 14 and 11 percent, because a number of those graduates from George Washington and Georgetown are in District of Columbia doing Federal service and Government jobs, doing research at the NIH and in lucrative suburban practices. There are fewer of the 16 percent at Howard who have gone into those fields. We do not feel that those fields qualify for the requirements of this section.

I will end here. From here on, it is a specific discussion of each point. You will see it in reading it.

Let me just repeat again one thing. We want to thank you for inviting MCHR to give testimony. We, like hundreds of thousands of District of Columbia residents, even those working in the area of health, even those in conjunction with these medical schools, would have had no idea that this bill was even being considered if you had not called us. This is why we think that public hearings are necessary.

We repeat in closing, we must have this before public consideration.

Mr. MAZZOLI. Thank you very much, Dr. Wolfe. I might make a comment in that regard with respect to the public hearings and the fact that you thank us for a chance to appear. We thank you, because this is the way that we get our ideas, is by having a lot of people here, those that are practiced at the art of giving testimony and who sit before us time and time again, and those like yourselves who make occasional appearances if at all. It might be a good lead-in for me to thank staff, because it is these people who worked so hard to get the word out and make the contacts and make the arrangements, like my associate Mr. Kirschten who put together all of these panels, and Ms. Fleischer, who helps him doing that. So in thanking us really we should thank you. But if anything, we ought to thank staff. They were really quite helpful to us.

Dr. Melnick?

**STATEMENT OF VIJAYA MELNICK, PH. D., ASSISTANT PROFESSOR
OF BIOLOGY AND PREMEDICAL ADVISER, FEDERAL CITY
COLLEGE**

Dr. MELNICK. I am Dr. Melnick from Washington, D.C. I am a premedical adviser at the Federal City College, but I do not represent the Federal City College in this testimony, or do not speak for the college. I am merely speaking as a citizen and drawing from my experience to make these comments.

I urge the support of the legislation, but with certain stipulations added to it. I urge the passage of the legislation merely because we cannot afford at this point to close down any medical schools because we are in dire need of health professionals across the country, and at that point we cannot think of closing down existing medical schools. We can only think of expanding such facilities.

AMENDMENT PROPOSED

However, it has to be pointed out that an exception has been made for Georgetown and George Washington Medical Schools. Even though they are private, they have this facility to come to the Federal Government for heavy subsidies when they run into deficits. If they look for such special treatment, then they should have special obligations on their part, and these obligations have to be fulfilled to their clientele in their immediate environment.

As a premedical adviser, I have had immense experience in trying to place premed students in medical schools and other paramedical schools across the Nation. I have found the receptivity of Georgetown and George Washington very much wanting and leaving much to be desired in sensitivity to these District of Columbia residents.

STUDENTS

As a faculty member of Federal City College and being in contact constantly with District of Columbia residents, since it is my obligation and it is an obligation of the College to deal with the District of Columbia residents, since the school was expressly conceived with that objective in mind, I have had to plead with several medical schools even to introduce the Federal City College as an existing college, because very few people know about its existence. And we would think that the schools that are in the immediate environment would know about the existence of the college, would know its goals and the clientele that it processes, and would be receptive to encourage these people to enter medical schools.

However, that has not been the case. I have placed my students in Rutgers Medical School, at the University of Pennsylvania, in New York downstate medical schools, Mississippi, Meharry, and there is only one student who has gotten admittance into the George Washington Medical School.

It has been pointed out by Health, Education, and Welfare panel, as well as other members here, that only 5 percent of the people are District of Columbia residents in these two schools. I think that is pathetic too, with these schools being here from 100 to 150 years, in the District of Columbia, that they have not been receptive to the people

that they see each and every day. I am not talking about paramedical training, although that is very important. We will see that when you go into paramedical training, the proportion of minorities and women increase.

At this point, I would like to diverge, because I have heard many times the statement made here that the only way to have doctors in a particular rural place is to have a doctor go in and marry the farmer's daughter. I hope that we keep in mind that the day is not too far away when a doctor will go and marry the farmer.

Also, there was a point made by both Georgetown and George Washington that they have consistently tried to increase the proportion of minorities entering their schools. I have here the data that I have obtained from AAMS. It states:

In 1971, they had 13 blacks—this is Georgetown—in 1972, they had 10 blacks; in 1973, they had 8 blacks.

In my mathematics, even though it is not new math, this proportion is less.

In George Washington, it is five, three, and six, respectively, and the number of residents is 11 in each school. And unless I am wrong—and the data I have been supplied with by the AAMC is wrong—I think this is a dependable source to quote from.

The numbers of women that have entered the schools are also not astonishing.

And there has been also a plea that the schools, when they ask for Federal grants, should also be receptive to affirmative action programs, such as increasing minorities, underrepresented groups and underrepresented segments of society, as well as women in the medical schools and other health professions. I do not see any such trend in either of these two medical schools.

Even though I support this legislation, I would add with all my heartfelt support, that a stipulation has to be made that some percentage, a definite allocation has to be made by both these medical schools for D.C. residents. Unless they make such a definite and written commitment, such request for legislation which involves periodically coming to the Federal Government for support, should not be considered.

Thank you.

Mr. MAZZOLI. Thank you very much, Dr. Melnick. And we appreciate your strong and courageous statement.

Mr. Cohill?

STATEMENT OF ORREN T. COHILL, VICE PRESIDENT OF THE INTERIM ADVISORY BOARD OF NORTHEAST GEORGETOWN MEDICAL CENTER

Mr. COHILL. I am Orren Cohill, chairman of the Georgetown Advisory Board of Northeast Georgetown Medical Center.

My approach to this question might be somewhat different from some of the approaches you have heard thus far. I have two very sincere concerns.

One is the reaction of students after we deny this kind of funding, and the reaction of the community when they hear that funds have been denied.

First, let me say I am extremely happy to be here and to appear before you to recommend the passage of H.R. 11108. With that out of the way, maybe I get back to some of the things that I think disturb me and also disturb people in the community.

First, we are in the midst of many crises-type situations. And, coming from the community level, I speak mostly in terms of those crises as they affect us and as they occur. If time would permit, I would like to develop for you some of the incidents that have occurred throughout the United States, and that have made for crisis kinds of situation.

Instead, I will just mention them in passing, hoping that you will recall how the various levels of frustration were raised to a point that made for civil disturbances and riot conditions.

During the past years, most of our college campuses have had or are faced with some type of civil disturbance. And of course, our hearts are saddened when we remember the students who were killed on college campuses, and I am sure that most of you can recall the Mayday civil disturbances that occurred here in the Nation's Capital.

But let us pause for a moment and give some thought to another crisis situation, the rising cost of health maintenance care that has blossomed into this frustrating approach. We often wonder about our forebearers who came here during the pioneer days and who developed the expertise of treating most of our common ailments with home remedies. Somehow, we have gotten away from some of the basic things that tend to reduce the cost of health care, for example, the use of midwives and other paramedicals.

COMMUNITY SERVICES

Today I would like to assure you that the people of Edgewood community are very proud to have situated in the Edgewood Terrace the Georgetown University Health Center. Needless to say, this is an HMO. We believe that health maintenance care reduces the cost. We also believe that money can be saved by educating in more effective uses of health resources. We believe that we can have a better understanding of self-help and preventive medicine. We believe that we can learn to make better observations in minor clinical illnesses, and we believe that if the cost of medical care is to go down, Americans must be taught to be healthy. Moreover, we believe that if we can continue to teach the community the four vital form and symptoms of an illness—for example, how to take temperatures, breathing rates, pulse rates and blood pressures—these methods at home would represent money in the bank.

Finally, we can no longer bathe in the luxury of spending \$75 billion for the Nation's health services, and 5 percent for health education. If we do, physicians and hospitals will have to cope with this endless flood of patients that will accompany an enactment of any type of national health insurance program.

And how will we from the community solve the problem of those who would rather stay at home and die than spend 12 or more hours waiting to be served?

Thank you.

Mr. MAZZOLI. Mr. Cohill, thank you very much for your statement. It certainly has given us some things to think about.

Mr. Kennedy, let me be sure that our record is complete on this point. You mention you have quite a bit of credentials for speaking.

Do you represent in your statement today and in your testimony today on behalf of this bill the NAACP, the D.C. chapter?

Mr. KENNEDY. Yes, sir.

Mr. MAZZOLI. I wanted to be sure. We want to be positive about the type of support.

Mr. KENNEDY. I came specifically representing the National Association for the Advancement of Colored People.

STUDENTS

Mr. MAZZOLI. Do you know, Mr. Kennedy, whether the NAACP has had any occasion to contact GW or Georgetown with respect to any difficulty in recruitment of blacks into the medical schools, and possibly with respect to services in the community?

Mr. KENNEDY. To the best of my knowledge they have not. The only question would be raised would be—and I serve as a member of the education committee—was whether or not this would in any way jeopardize Howard University. I assured them that Dr. Cheek at Howard University supported this proposition, and they authorized their approval.

Mr. MAZZOLI. I wish you luck in your dissertation. I know that is a tremendous undertaking. I hope it all turns out very well for you.

Mr. KENNEDY. Thank you, Mr. Chairman.

Mr. MAZZOLI. Dr. Wolfe, if you could give us maybe a fairly succinct description of your organization. I am not sure that that was too well defined for the purposes of our record, and for the members of our committee who may not be here today who will study the testimony before making judgment.

What does your organization actually attempt to do, and how is it structured?

Dr. WOLFE. MCHR is a national organization. We have 30 or 40 active chapters in different cities around the country. Washington is one of those cities that has a chapter. The organization started in 1964 in support of the civil rights marches in the South when physicians and nurses and so on, went down to provide medical presence during those demonstrations. It has subsequently taken, not a different direction, but additional directions, in the sense of trying to bring about some basic changes in the health care systems in the country. We have projects that deal with prison health, national health insurance, occupational safety and health.

I could name a number of areas. We are still as interested in civil rights as we were back in 1964 marches. We are also interested in many other human rights and patients' rights within medical facilities and services.

Mr. MAZZOLI. Would you, Dr. Wolfe, be able to, just offhand, estimate the number of members you might have in the chapter, and perhaps how many medical people?

I assume you take in lay people as well as medical personnel?

Dr. WOLFE. We do. Our membership also includes anyone who is working in health, or even interested in working in our organization projects which are dealing with health care. So many consumers are in it as well.

Locally, we have a mailing list of about 300 people. There are certainly not that many who are active. At our last meeting we may have had about 40 people.

COMMUNITY RELATIONS

Mr. MAZZOLI. I noticed on your last page, Doctor, you list those who contributed ideas to the testimony, and there are a number of individuals and groups. This ties in with your statement, it seems to me, on outreach, and the idea of public hearings, and your comment about our having them here, and also your comment about public hearings with respect to the applications for the money.

Do you think it is possible to have noncombative peaceful but fervent public discussions with respect to the providing of health care and with respect to the proper role of the university medical centers in the big city towns like Washington.

Can you actually have a public hearing without having so much rancor, and without having disputes, and without having a really—a good public hearing where business is done and people leave knowing that they were in a spirited meeting without having the feeling that everybody's mind is closed?

Dr. WOLFE. I think it is possible. I know there has been dissension at meetings. We called meetings, or there are other groups who call meetings in this city for hearings of one sort or the other to solicit community comment, and not a lot of people come. But the people hear about it, and they knew that the meeting is going on, and they talk to their friends and neighbors about what went on at the meeting. So at least they become informed, whether they attend or not. The number who attend, though, I think would be able to bring about a good discussion.

Mr. MAZZOLI. You feel it could be controlled.

Now, perhaps as a member of your group, how would you assess the relationships at George Washington University and Georgetown have with respect to the community as you see it?

Dr. WOLFE. What kind of relationship?

Mr. MAZZOLI. To the community?

Your statement dwelt at some length on that factor of their responsibilities and if they have certain rights and certain responsibilities, how do you envision these?

How do you think they are satisfying their role and their mission?

Dr. WOLFE. The main examples that I gave about taking services away from District of Columbia General is one thing of real concern. Another is the firing of hospital workers who are already partially trained—well trained even—for the jobs that they were holding in the health system.

I know that at one time George Washington was interested in a neighborhood health center in Southwest, and one of the people on the staff there said to me, we wanted to take over their center and they would not let us, and stomped his feet on the floor. This is a concern to me that if they can set up additional services, would they take over the neighborhood health centers when the people do not want them to. This disturbs me.

They also called a community meeting in Southwest to ask for people's suggestions as to things that they might do for the com-

munity. The things that were requested, they rejected, and the things that the community rejected, they proceeded to do.

Mr. MAZZOLI. Dr. Melnick, have you found the relationship between Federal City in your role as a premed counselor and the relationships with George Washington and Georgetown to have been fruitful as far as you are concerned with placement of these young people?

And if not, and I would assume from your statement that they have not been totally uneventful, what would be some thoughts on how this might be improved, short of quotaing people in? We find that as much a discriminatory practice as quotaing people out.

We are probably not going to be able to set up, even if it ever were a desire, to set up numbers. So, short of that, how do you believe that attitudes and relationships can be improved, leading to the one goal that we are all striving for—that is, a better contact between the young resident of this community and a possible career in medicine?

STUDENTS

Dr. MELNICK. If quotas cannot be stipulated, then I think some preferential treatment should be given. Here I have a handbook from AAMC that lists the requirements of every medical school in this country, and almost 85 percent of them say, preference will be given to the State residents, such as Vermont residents, or New York residents, et cetera. And I also heard a statement made here before, about the University of Rochester being a private university and New York funding it in spite of the fact that it need not take New York residents. But as per the information that I have from this book they had zero nonresidents in that school. They were taking 100 percent residents in that school, even though they were privately owned.

I am only urging that since these two schools are located within the District of Columbia and have prime real estate in the District of Columbia, and now they are urging public funding for these two institutions, that they act in some fashion as State medical schools for the District of Columbia and give preference for District of Columbia residents. And if quota is a bad word, then I think some way can be found, even on an unwritten or informal basis, that they would do everything that they can to make this definite commitment.

I do not think that commitment has been made. They have programs in Michigan, for example, where they take high school students and expose them to several summers with a specific doctor or hospital program. The students who go through these programs show high motivation to enter careers in medicine. These are bright promising youngsters. Without exception, these people turn out to be very much interested and highly talented doctors and doctoral students, and I think such programs could be instituted for deserving, promising youngsters from the high schools here, who may not be able to travel great distances to attend such programs elsewhere because of their dire economic status. These institutions could do that. In the same way that the National Institutes of Health and the Naval Medical Center and the Walter Reed Hospital make their own contacts between themselves and these medical schools, contacts could be made for youngsters from the District of Columbia to be at these various places during the summer to expose them to medical research as well as practice. That is one way.

PARAMEDICAL PROGRAMS

The other way is programs for veterans for example—Washington's proportion of unemployed veterans is immense. There are several veterans who are trained medics. These people, with very little training, could be converted to civilian paramedical training, especially in the area of emergency care. I know that the District of Columbia Fire Department, as well as the Montgomery Fire Department, are thinking in terms of quite a few people in the area of paramedic firemen, fashioned much after the TV program "Emergency" that comes out of Los Angeles.

I think in these cases the medic-trained veteran would be an ideal candidate, and we tried to do something like that. In fact, I wrote a proposal for that, and it was turned down because I did not have a medical school or hospital attached to my school. They felt that in a training such as that, there should be a hospital or medical school attached to such a program. I can see their point.

But such programs could be run between Federal City College students, or any undergraduate college of the metropolitan area, and these university hospitals and colleges.

I include Howard in that. Howard's record in the number of residents is not all that good either. According to this book, they had only something like 15 residents out of 130. I do not think that if many interested youngsters from the District of Columbia enter Georgetown or George Washington, I do not think it is going to threaten the clientele of Howard University. Howard has always regarded itself as a national minority school. It was chartered for the purpose of black education mainly, and Meharry and Howard have been traditionally such places. We can question whether they should continue as such, but they now belong to a different category, and should not be clumped together with Georgetown and George Washington.

Mr. MAZZOLI. Thank you, Doctor.

Mr. COHILL, the residents in Edgewood are satisfied with the treatment and the attitude shown toward them by the doctors and nurses of the staff of the health clinic?

Mr. COHILL. Yes; we are very satisfied. But that has not always been the case. In the initial stages of trying to get somebody coming to Edgewood to attend health meetings, the only people that I could get were Georgetown. And when they did come on the scene, they, like others, were looked upon with suspicion. We felt that Georgetown was like George Washington, they were too sophisticated to come down into the community and deal with the dirty and complex health problems that we have. But, to our surprise, and through many, many meetings, we learned that they were sincere and they did want to come out into the community with an Outreach program. They were willing to make changes that would take them out of that sophisticated standard and put them down on the level where they could offer this kind of health care.

For that particular reason we still have this partnership arrangement. That is, that our advisory board, along with Georgetown, make the decisions as to what happens. Prior to now, black people and poor people in the community had no say-so about the kind of health services that they were getting. In this way, the community helps design, they share the responsibility as well as Georgetown.

Mr. MAZZOLI. Thank you very much.
Congressman Gude?

Mr. GUDE. Thank you, Mr. Chairman.

Dr. Wolfe, I would like simply to compliment your organization, as the chairman has already indicated, for being a conveyor of community feeling. I note on your list on the last page, that we even get down to the patients with complaints about hospital services. You have carried out a real function in democracy here, and I think it is great. It was probably due to our staff that that has come about. Regardless of whether your organization represents 10,000 people who pay their dues here in Washington or not, it has been very good to have your testimony.

FUNDING

There is one point that I would like to ask you about. All through your testimony, you refer to the fact that this money would come out of the District of Columbia budget, and that this money would be taken away from other functions of the city. Of course, this is one of the questions that we have discussed here, whether this is going to come from Labor-HEW Appropriations or come from the District of Columbia Appropriations Subcommittee. You would seem to make a good case that the legislation should stay as is, because it does not come out of the District of Columbia budget. It would not be taking money away from other programs.

I think some of your points are well-taken, in the context that there might well be changes in the way these institutions operate in reference to this city, if this were to be part of the District of Columbia budget.

Dr. WOLFE. My concern is, this committee has been notorious for subtracting from the District of Columbia budget every time categorical funds come into the District of Columbia. It has happened repeatedly. The thing that we experienced last year was when HEW put special funds into the District for VD, that that amount was subtracted from the District of Columbia health budget. Therefore, the VD program in the city could only use that money to carry on operations as usual. They could not add anything new to their program, other than what they could get through volunteer services, which they did. They pulled together to some extent.

I heard this from several of the groups that we talked to. They were very concerned that this committee was going to do as it has always done, that if they see other funds coming into the District they will cut the District of Columbia budget.

Mr. GUDE. I can see your point.

Looking at these two institutions, say, in reference to some of the basic medical research that they carry on on a national scale—for example, the hypertension research that was mentioned. That not only gives some of the citizens in the city some advantages over citizens of other areas, it is really a research program which goes beyond Washington or the metropolitan area. It is very important research that would be valuable to all citizens of the United States, that happens to be carried on in these hospitals here.

So, to that extent, if you say this hospital or these two hospitals must serve the people of the city, you are not suggesting that you

would be opposed to these basic research programs in which these hospitals are put in a national position?

Dr. WOLFE. I feel research is essential to medical practice, is essential to the training of medical students. But I do see it as serving a national purpose by and large, and that those funds should largely come from national sources.

As far as medical education funding for services, most of the HEW funds that are put into the medical schools to provide services require that only a small percent of that be used for indigent care. The requirement is a fairly low percent. The community looks upon this provision of a small percent for the poor as tokenism, because the percent that is set is nowhere near the percent of poor people in the population. They would like to see a greater percent of service funds used for the indigent. I could see a bill like H.R. 11108 if it funded services specifically requesting that all of those services be provided in D.C. Then you would erase the tokenism aspect of providing care to the poor and put the total amount of funds into that type of service.

Mr. GUDE. Let me say, as a sponsor of this legislation, that my concept is that if it should be enacted and become a budget item, it would not be subtracted from the amount of funds that the District of Columbia Appropriations Subcommittee allows to the District.

Dr. WOLFE. I would like to see that written into the bill.

Mr. GUDE. That is certainly the spirit as far as my sponsorship goes. I am sure it is shared by the other members.

Mr. MAZZOLI. Congressman Stark?

Mr. STARK. Dr. Wolfe, I would particularly like to thank you for your testimony. I would also like to comment that I wish that your Medical Committee for Human Rights had been brought about in 1962, when in Greenville, Miss. the closest thing to a physician we could find was a surgeon whose surgical garb consisted of a sheet with two eye-holes in it, which was not an unusual garb for those days. We would have welcomed you having been there a little earlier.

LABOR RELATIONS

I wanted to ask whether you know whether the Georgetown Medical School Hospital is unionized?

Dr. WOLFE. I think I am right that Local 82 is there.

Mr. STARK. All nonprofessional personnel?

Dr. WOLFE. Union 1199, which is the same union which had its workers fired at GW, has tried to organize at Georgetown. They got a very different type of response from that at George Washington. During the whole union effort, the hospital administration instructed the supervisors to not allow the workers to wear union buttons, and some of the people were fired simply because they wore them. Whereas, at Georgetown, the supervisor and other people were told to give no flak to them at all. In that way, actually, sort of by their passivity toward them, they squelched the union effort. They did not have enough issues to build around in order to get enough backing of membership.

Mr. STARK. To your knowledge there is no collective bargaining unit at Georgetown University Hospital?

Dr. WOLFE. There are some small ones. I think the cafeteria workers. I am not sure.

Mr. STARK. Are the hospital nurses in the District of Columbia unionized?

Dr. WOLFE. Nurses try to regain their benefits more through, I think, the American Nursing Association and the League of Nursing. I do not think they have actually unionized.

Mr. STARK. That is not true in California.

Do you know what George Washington Hospital's labor relations are generally?

Dr. WOLFE. I do not know about past experience. I know that the union has had an effort for about 18 months, maybe a little longer, at GW at this time.

Mr. STARK. I would just point out that no bill, I think, would pass the House of Representatives that would provide money to organizations that did not allow fair representation of unions or that in any way, openly tried to prohibit labor from trying to organize. I think the labor issue that has not been raised before would be a large and significant one.

Dr. WOLFE. I am concerned that the hospital workers at GW—I do not just know that much about the Georgetown situation. The workers were not given a raise, as they requested, in proportion to the cost-of-living increase. Yet the hospital said it had come out in the black this year.

What we are concerned about is that they diverted the additional moneys from the hospital into the medical school to support the education program, and that the workers therefore, were not given an adequate living wage increase.

COSTS

Mr. STARK. I did notice you raised the question of cost in your testimony, requiring examination of the costs relative to both medical schools. And to the extent that you have any information about excessive costs in any areas, that would be helpful if you could submit that.

Dr. WOLFE. It is in the written testimony.

Mr. STARK. Then there was the question of moralizing in addition to antibiotics in the venereal disease clinic. Any evidence of that would be of interest to me, as to what types of moralizing is dispensed with public health.

I would encourage you to keep up this type of research, because it will help us attain or insure that if any Federal money does go into medical education in the District, it does indeed serve the people of the District in the way that they best perceive their needs, not the way that some professional feels that they should be administered. So I would appreciate very much your comments.

Dr. Melnick, you have statistics, I suspect, on the number of applicants from your schools and perhaps other schools. To the extent that those were not read in the record. I would appreciate it very much having as many details as you could add and submit to us for the record.

[The material referred to is in the appendix.]

STUDENTS

Mr. STARK. I would further ask whether you suspect there is any great disparity in the percentage of D.C. students admitted to other medical schools who matriculate but do not graduate, and if you think those figures may be weighted out of proportion.

Dr. MELNICK. Are you talking about the attrition rate?

Mr. STARK. Yes.

Dr. MELNICK. The people who enter who do not quite make the grade, do not complete the program?

Mr. STARK. Yes.

Dr. MELNICK. I was told that Georgetown did have a high percentage of attrition rate among its black students. I do not know the exact statistics. It was not made available to me. I can only report what I heard.

I think, as far as the attrition rate is concerned, several people have been concerned about this aspect, and I think Macy Foundation has financed several grants just to study this problem of attrition among minorities who enter graduate and medical education. I think one thing has to be said, and that is, if the students are well selected from the minority group, from women or from any given group, that there are enough potentially talented people who can make the grade, and I think that the excuse that this particular segment of people are only capable of paramedical work, or that if they are in medical programs, flunk out in a given period of time without making the grade, is a fictitious one, as evidenced by my students who have gone to these other medical schools, and have done very well and are still hanging on. For that matter so is the student who entered GW.

So I do not think that, speaking from my own experience, my students have contributed to the attrition rate. In schools that are sensitive to the problem of minority students entering a large sea of other students, who, as my students tell me, "We stick out like a sore thumb," and with the other pressures that come to the medical school students, which make many of them think of dropping out at various periods of time, this added pressure that if you do not perform maybe the next set of your people will not be taken in because you are not performing, that you are being taken as a model, whether you make it or not, you are going to be judged not only for you but for generations to come. It's a tremendous pressure on a young person. And with some, perhaps with the handicapped education that they would have had previously from high school, I think enrichment programs, supplemental programs, and tutorials, et cetera, would help. Where they have been available, attrition rates have been very, very low.

Mr. STARK. I appreciate that, and I am inclined wholeheartedly to agree with you and Dr. Wolfe. My feeling is, I too prefer to have these sorts of things written, and again would ask you for as much detail as you can give us to add to the record.

Or, if some of these things come to you as things you have heard, if you will indicate where we, through our own staff, through our own investigation, could develop the statistics, we will be glad to do that.

Thank you both, and all four of the panel for taking the time.

COMMUNITY RELATIONS

Mr. KENNEDY. Mr. Chairman, if I could ask one final comment. I do not want to leave the record on behalf of the community negative with respect to Georgetown or George Washington University.

In my statement in chief, I indicated that I have been working very closely through the consortium of universities with both these institutions. Only yesterday I invited the provost of Federal City College to join me at lunch at Georgetown University, where we discussed our mutual and joint program of exchanging benefits.

We have already discussed with Georgetown community relations specialists how Federal City College and Georgetown students could exchange on a 1-to-1 basis. We are moving in that direction with other institutions.

I do not want to let this record show that these institutions are totally negative.

One final thing. In terms of accreditation of Federal City College, these institutions and their presidents have come out 100 percent in support of us in the public sector. I believe we have an equal responsibility to support them, as they provide a service to our community.

Mr. MAZZOLI. Thank you very much.

Counsel?

Mr. HOGAN. Dr. Melnick, how long have you been with Federal City College?

Dr. MELNICK. This is my fourth year.

GRADUATES

Mr. HOGAN. How many graduating classes?

Dr. MELNICK. We have only had two graduating classes so far.

Mr. HOGAN. Your experience in placing the student, I assume goes to those 2 years, at least for medical school?

Dr. MELNICK. Correct.

Mr. HOGAN. When you are giving us, the committee, the information on the placement, could you indicate where you have placed your students and how many are still continuing on in the program?

Dr. MELNICK. Surely.

Mr. HOGAN. One further question. If I understand it, Federal City College is not accredited?

Dr. MELNICK. Yes.

Mr. HOGAN. Is that a factor in acceptance of students at some of these medical schools?

Dr. MELNICK. As far as the science programs are concerned, the natural science division of the school of natural and applied health—sciences as it is called now—that school has a provisional accreditation, which is what all schools have before they come up for full accreditation.

In order to get full accreditation, you have to have at least graduated one class, which we did last June. So we are hopeful in this coming year we will be accredited.

Yes, that has been one of the questions that some schools have raised. In fact, I had that question raised from the University of California.

I have been able to give them the evidence of provisional accreditation, which is all we would have been expected to have, and also that these students have gone to summer programs at Harvard and Meharry where they have performed excellently. Those people are able to attest to their talents and potential. On the basis of that, they have been accepted.

Mr. HOGAN. I do not want to delay the committee.

How many have you placed in medical schools?

Dr. MELNICK. Five last year.

Mr. HOGAN. How many the year before?

Dr. MELNICK. Two.

The year before that, it was not a real graduating class. There were students who had either transferred—but our first graduating class was last year.

Mr. HOGAN. Your basic experience is five?

Dr. MELNICK. Right.

Mr. HOGAN. Did you place any of these at Howard University?

Dr. MELNICK. No. There was one, I think the year before last, who entered Howard University.

Mr. HOGAN. Your experience with Howard is relatively the same as it is with George Washington and Georgetown?

Dr. MELNICK. Yes.

Mr. HOGAN. Thank you.

Mr. MAZZOLI. Thank you very much.

If there are no further questions, the panel is excused, with our thanks for a good job and for a lot of help. And the testimony is complete, unless there are any further statements. If any of the members wish to edit or revise or add to their statements they can do so.

Also, I would like to make it a matter of record that Counsel Hogan and I will try to work together on setting up an ad hoc meeting with the HEW people and certain members of today's panels and try to work out any difficulties about the medical programs.

Thank you very much.

We will now stand adjourned.

[Whereupon, at 5 p.m., the subcommittee adjourned, subject to the call of the Chair.]

APPENDIX

[Under authority previously granted, the following statements and communications were ordered printed:]

STATEMENT OF MR. PAUL ROGERS

Mr. Chairman, thank you for the opportunity to submit written testimony before your Subcommittee on H.R. 11108, a bill to extend for three years the Medical Dental Manpower bill of the District of Columbia. I regret that my duties as Chairman of the Public Health and Environment Subcommittee prevent my personal appearance before your Subcommittee today.

The rationale for this legislation is to provide support for the operations of the School of Medicine at George Washington University and the Schools of Medicine and Dentistry at Georgetown University. H.R. 11108, a bill which is identical to H.R. 11535 which I introduced last session, is consistent with the purposes of the National Health Manpower Act of 1971, which was passed out of the Subcommittee on Public Health and Environment. On a formula basis of student enrollment, H.R. 11108 provides for a limited capitation award to meet operating deficits.

The National Health Manpower Act of 1971 requires that medical and dental schools receive support funds from the state legislatures. To be eligible for financial distress funds for medical and dental schools in the National Health Manpower legislation the recipient schools must have a long range method for the solution of their financial plight. The need of some additional financial support for the private medical and dental schools in the District of Columbia is a constant that nearly all U.S. medical and dental schools experience and meet from various state programs. Because of their unique location in the District of Columbia, these schools at Georgetown and George Washington must obtain support from a Federal assistance program, separate from the National Health Manpower legislation.

Since the Georgetown and George Washington University Medical and Dental Schools are national in student body composition with 1,835 students from 50 states and the District of Columbia and nearly 11,000 graduate doctors distributed among 50 states, continued Federal support of these schools is in the national interest.

During Fiscal 1973 these schools received grants under national financial distress legislation. They met this requirement in this special financial distress act.

For FY 1974, financial distress applications of the District of Columbia Medical and Dental Schools are pending until an increase by legislation of the amount in the National Health Manpower Act from \$10 million to \$15 million in this distress category. Once again, H.R. 11108 is deemed a necessary solution for their special financial distress needs.

For these reasons, I, along with several other members of my Subcommittee, have sponsored an identical bill to the one introduced by Mr. Diggs and members of the District of Columbia Committee, and I urge your Subcommittee to give careful consideration to this meritorious legislation.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., January 24, 1974.

Hon. ROMANO L. MAZZOLI,

Chairman, Subcommittee on Labor, Social Services, and the International Community of the House Committee on the District of Columbia, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am extremely pleased to communicate my support of the bill, H.R. 11108, which would extend for three years the District of Columbia Medical and Dental Manpower Act of 1970.

The continued success of the private medical and dental schools in the Nation's Capital depends substantially upon passage of this bill and its subsequent funding. You will receive ample testimony to the fact that unless adequate additional funds are forthcoming from either this legislation or from the distress grants of the Department of Health, Education, and Welfare, the level of medical education imparted by these schools will decline or altogether cease.

While others in the Administration may tend to take a different view, I sincerely believe that there can be no let-up in the numbers of persons educated as doctors or dentists in our society. The need for physicians is amply demonstrated by the extraordinarily high incomes earned by those who are learned in these healing arts and by the fact that both our rural and inner-city communities lack in these essential medical services.

Thus, as I look towards the future of a continuously growing America and an ever expanding population, I believe that the facts compel us to continue federal support of medical personnel in every field—medicine, dentistry, and nursing—and at every governmental level. In the District of Columbia, we are particularly fortunate to have three great medical schools through which we can signify the level of our commitment to the health of our people.

Unfortunately, there are few urban communities where the need for medical personnel is greater than our own backyard. I am sorry to have to note that fact. Thus, while I fully support this bill, I hope that this Committee will seek to couple the grant of these monies to some affirmative program that will assure our inner city residents of the same quality and quantity of care that our suburban brothers and sisters have.

As I understand the facts, more than 80-90% of the graduates of both George Washington and Georgetown leave the capital city to practice elsewhere. I urge you to closely question the advocates of this legislation to determine the level of commitment to recruitment of District of Columbia residents and the efforts made to entice the graduates to remain in the city.

Just as we did by enacting the original capitation grant program through PL 91-650 in this Committee, I hope that we will establish new ground by beginning this affirmative action program. PL 91-650 was the prelude to PL 92-157, the national legislation that is the basis for our current national student capitation formula programs. The opportunity is again before this Committee to lead the way, and I hope that we accept it.

Finally, I want to note the fact that two nursing schools which operate in our city are not covered. The allied health professions are as important to the national and community health as are these schools. As a total portion of the bill, however, they would constitute a dollar amount of less than \$500,000 per annum.

Without financial assistance, I can assure you that the nursing school at the Washington Hospital Center will probably close within the year. It is likely that the nursing school at the American University will also close if some way is not found to substantially reduce and end the deficit there.

I hope that you will closely question the witnesses to determine the best way to assure the existence of these schools. Perhaps they can be absorbed into the medical schools or perhaps they can be directly funded by an appropriate amendment to the bill. Direct funding, I believe, is both practical and advantageous, and I urge you to fully explore the implications of these suggestions upon both the Washington Hospital Center and the American University.

A nation's strength and a city's reputation can only be as long lasting and as secure as its commitment to the people's health. I do not believe that we will want to jeopardize the long and arduous tasks that these schools have undertaken to make our nation and this city a recognized medical center.

Accordingly, I urge support of the bill, and I urge the Committee to adopt the recommendations I have made in connection therewith.

With kindest personal regards, I am

Sincerely yours,

WALTER E. FAUNTROY,
Member of Congress.

TESTIMONY OF WILLIAM M. BUCHER, EXECUTIVE VICE PRESIDENT AND DIRECTOR,
HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC.

Mr. Chairman, my name is William M. Bucher. I serve as the Executive Vice President of the Hospital Council of the National Capital Area, Inc., a voluntary organization of thirty community hospitals in the Washington Metropolitan Area.

I have served in this capacity since 1951 and I have been intimately involved in the area health manpower program including those provided by the Universities under the legislative request before you today.

The Hospital Council has had as one of its major programs the provision of health manpower of a quality and quantity necessary to meet the health needs of our metropolitan community. It has developed and operated a Center for Continuing Education for physicians and allied health personnel. Further, the Council has developed educational programs for health personnel in hospitals at the job entry, skill improvement, and management levels. Working with programs under the Departments of Labor and HEW, for illustration, we have trained upwards to five hundred health and hospital workers in a single year.

Because of this responsibility and experience, I am pleased to appear today in support of the extension of the District of Columbia Medical and Dental Manpower Act of 1970. My testimony will also support the fact that the services provided by these medical centers by affiliation, and otherwise, with the hospitals throughout the Washington Metropolitan Area are essential to the quality of health care enjoyed by our resident population and our visitors both national and international.

The Georgetown and George Washington Universities have assumed an impressive role in contributing to the sophistication of health care in this community. They have been intimately involved in the problems association with the dissemination of new and researched life-saving medical techniques and procedures both within the University hospitals and the community hospitals. The provision of multi-faceted university medical center programs are geared to the needs of all income segments of our population.

The Georgetown University Medical School's teaching faculty, house staff and students, for illustration, are found in Arlington Hospital, Children's Hospital, the Hospital for Sick Children, and the District of Columbia General Hospital. In addition, the Georgetown University Medical School maintains medical specialty affiliations with the Washington Veterans Hospital, Providence Hospital and Sibley Memorial Hospital. Further, from time to time, staff specialists are made available to supplement and plug voids within the District of Columbia Government's health service. The Georgetown University Dental School program has similar community involvements.

Next, I would like to illustrate the important contributions of the George Washington Medical School, its University Clinical Center and its University Hospital to the health professional area and the entire metropolitan community. This university's medical school teaching faculty, its hospital house staff and its students can be found in its affiliated programs at the Columbia Hospital for Women, the Fairfax Hospital, St. Elizabeth's Hospital, the Washington Hospital Center, Children's Hospital and the District of Columbia General Hospital.

George Washington University's Medical Center has also extended its educational programs and specialty services throughout the community into Walter Reed Army Hospital, the Bethesda Naval Hospital, the Armed Forces Institute of Pathology and the National Institutes of Health.

The George Washington University Clinical Center recently opened its impressive Comprehensive Care Program. This prototype service center is one of the few of its type in the country. It provides its patients from all income levels with the highest quality of care available at the most economical rate. Both Universities became deeply involved in the development of Health Maintenance Organizations before the passage of Public Law 93-222 on December 29, 1973.

Mr. Chairman, these are some of the facts which illustrate the George Washington University School of Medicine and Georgetown University Schools of Medicine and Dentistry position as integral elements of the health care system in the Washington Metropolitan Area. The absence or curtailing of the services provided by these institutions would seriously jeopardize both the quality and quantity of health care here at a time when federal programs and the public demands for health care are increasing at an unprecedented rate. Another point worthy of emphasis is that these two medical schools and the dental school perform the function of State schools. Their staffing of the public health institutions, especially at the District of Columbia General Hospital, is a responsibility that in most States is performed by State schools.

The Metropolitan Washington Area is a national resource and a national responsibility. Statistics show that over 70% of the residents in the Metropolitan Area are employed by Congress and the Federal Government, or their supportive and related industries. By virtue of services that these schools render within the Metropolitan Area hospitals, they constitute the health manpower resource for the residents of the Washington Metropolitan Area. It is, therefore, sound rationale to consider deficit funding at the national HEW appropriation level.

In terms of dollar service contributed by these Schools of Medicine and Dentistry to the Washington Metropolitan Area, I would like to point out that the services rendered by these medical centers, for which they do not receive reimbursement, are calculated in millions of dollars. One such program is the Medical Charities Program which provides hospital and clinical care to indigent patients by the Medical School staffs of these University Hospitals. In the fiscal year 1972 services were provided to the District Government patients which cost millions of dollars above the amount that was actually paid. Congress has provided no economic relief from this problem within the fiscal 1974 D.C. Budget.

In conclusion, there are three basic points:

1. It can be amply demonstrated that the financial assistance requested for these Schools of Medicine and Dentistry differs from other educational programs, since the medical centers of these schools provide unenumerated services to the Washington Metropolitan Area which run into millions of dollars annually.

2. Since the Federal Government is by far the largest employer in the National Capital Area, it assumes the legislative and financial obligations to ensure the operation of the Nation's Capital as a national asset. It should provide the comparable "state-like" funds to allow these schools to serve the health needs of the National Capital Area.

3. The George Washington University School of Medicine and the Georgetown University Schools of Medicine and Dentistry are in dire need of financial assistance as their accounting records demonstrate. It is less costly to the Federal Government to support their needs rather than to take them over.

Therefore, I urgently recommend that your Committee act favorably on H.R. 11108 since these schools are essential elements of the health care system for the residents and visitors of the Washington Metropolitan Area.

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION AND THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS

Mr. Chairman and Members of the Committee:

The American Dental Association is grateful for this opportunity to present this statement in support of H.R. 11108, a bill to extend for three years the District of Columbia Medical and Dental Manpower Act of 1970.

The ability to meet the dental care needs of our country now and in the future depends upon a financially stable system of dental education. In most instances this requires a sharing of costs among state, federal and private sources. In the absence of state legislature for the District of Columbia, it is entirely appropriate and proper to provide authority for special assistance to the Health Professions Schools covered under H.R. 11108. This would be consistent with the recent developments that have occurred in a number of states which now provide direct support to private dental schools.

The fight to put each existing school on a sound financial basis has a basic, economic rationale. Obviously, each region of the nation needs to have a certain number of educational institutions producing the dentists its citizens must have. Any existing institution that fails must, of necessity, be replaced sooner or later. It is, however, a fair more expensive proposition to build a new school than it is to

preserve an existing institution with its buildings, its equipment and its faculty. Additionally, the time gap between the first planning of a new school and the time when it graduates its first dentists can be as much as ten years.

The basic cause of the financial crisis of the dental schools today lies in the spiraling maintenance costs and in the ever-growing base of knowledge that a health professional must have in order to give modern, high-quality care. On a per student basis, it now costs a school some \$11,000 on the average to provide each enrollee with the necessary education while it receives, in income from all sources, some \$2-3,000 per student less than this figure. Such deficits as these need to accumulate for only a short time before they become unbearable and a school faces the necessity of phasing the dental school out of its curriculum.

Dentistry is the most expensive professional health education for the student as well as the schools, primarily because of the highly specialized instruments and equipment that must be utilized. A main source of income for professional health schools, of course, is tuition and fee charges to students. Schools have raised these charges faster and higher than they wish in an effort to keep the gap between income and expense from broadening fatally.

We are now at a point where typical tuition and fees that a student must pay can range as high as \$11,000 to \$15,000 during his four years. This is entirely exclusive of such personal expenses as room and board. And these costs, it must always be remembered, come in addition to the costs of four years of undergraduate education that a typical dental student has already undergone. Clearly, tuition and fees can go no higher if dental education is to remain accessible to a broad range of scholastically eligible students. Dental education is not heavily endowed from private sources and thus does not draw on that kind of resource in its effort to maintain itself.

Of the nation's dental schools, the financial crisis has been most crushing for those affiliated with private universities. The Association believes philosophically, that it is infinitely better for the nation to have its professional health education system rooted in both private and public universities. But even more to the point, the pragmatic fact is nearly one-half of the existing 59 dental schools are private. They produce some 50 per cent of the annual graduates. They must, then, be preserved.

There has been, in the past five years, an increasingly clear recognition by the public sector of the priority it needs to give to professional health education. This has led to federal legislation presently embodied in the Comprehensive Health Manpower Training Act of 1971. It has also led a number of states and jurisdictions to the realization that they too must be attentive to the needs in this area. Precedent now exists whereby a state or jurisdictional authority would provide to a dental school within its purview, whether private or public, operating funds based on an equitable formula derived from its enrollment, graduates and attendant educational expenses. It is the conviction of the Association that such arrangements are, at a minimum, highly desirable and, in some cases, essential.

Despite the increasing funding available to private schools for dental education under the Health Manpower Act, the increases will not meet the need for continued support at present levels of education. Present legislation will soon phase out the availability of specific "financial distress" money and force private institutions in a monetary crisis to compete for operating expense money with better-endowed schools.

It is obvious from the figures cited by the Dean of the Dental School that Georgetown University School of Dentistry occupies a vital position in the District of Columbia. Without it, the District would find it, in our view, impossible to provide its citizens with the dental care they need. It is this relationship that we believe should be the focus of the Committee's judgment on the measure before it. The American Dental Association strongly urges approval of H.R. 11108.

STATEMENT OF MINNIE BOWICK EDWARDS, VICE PRESIDENT OF THE CENTRAL NORTHEAST CIVIC ASSOCIATION OF THE DISTRICT OF COLUMBIA FOR GENERAL SUPPORT OF GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

Mr. Chairman and members of the committee, my name is Minnie Bowick Edwards, a citizen of the District of Columbia. I represent the Central Northeast Civic Association as its Vice President. I am also Chairman of Ward 7 in the District, a member of the President's Bicentennial Committee for the District for

area 3, and a member of many other civil groups. As a community leader I appear today on behalf of Georgetown University School of Medicine. I am a supervisor of their field staff of medical interviewers who conduct door-to-door screening for hypertension in the inner city. I appreciate this opportunity to give you an evaluation of the program as carried on by the Georgetown Medical School in the area of hypertension.

High blood pressure is the most devastating disease there is in the annals of medical research. It is commonly called the silent killer for there is often no attendant pain. High blood pressure is a leading cause of strokes, heart attacks, arteriosclerosis, and kidney diseases. Many medical authorities have placed hypertension among the nation's most pressing priorities. Georgetown University Medical School under the guiding skill of Dr. Frank A. Finnerty, director of their Hypertension Clinic at D.C. General Hospital, is doing a tremendous job at the community level. It is here where we detect, treat and prevent hypertension, thus staying off strokes, heart attacks or other attendant fatal diseases.

Mr. Chairman, it is my wish that you and your committee think kindly of the H.R. Bill 11108 to its maximum allotment for both medical and dental students enrolled at Georgetown University. This amount, I believe, is up to \$3,000 per dental student and \$5,000 per medical student. Without this upward bound fund, Georgetown University School of Medicine would find it difficult to function. Since 48% of the individuals in one study by our Georgetown University clinical doctors had high blood pressure, this is a high potential mortality rate to conceive. Such fatalities are precisely what will happen if Georgetown University is not adequately funded to continue its service.

Finally brethren: in the language of the greatest Healer of them all, I beg of you to think on these things. Thank you, Mr. Chairman.

STATEMENT OF HENRY J. JOHNSON, JR.

Mr. Chairman and members of this committee, my name is Henry J. Johnson, Jr. I serve as President of Rogers Memorial Hospital's Chaplains Staff as well as President of the Capitol Hill Group Ministry. I am an active member of the Baptist Ministers Conference, "Universal Justice and Goodwill" and "One Hundred Baptist Ministers." I represent the Baptist Ministers Conference of the Washington Metropolitan Area and in particular the Southeast and Northeast sectors of Washington. I believe that the work done by the medical schools at Georgetown University and the George Washington University at Rogers Memorial Hospital and the D.C. General Hospital is of great service to the patients attending these hospitals.

I understand that these schools are in need of money from Congress in order that they may continue to do their work. For this reason I strongly support the bill in Congress H.R. 11108.

Thank you for allowing me to present my testimony.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., January 23, 1974.

Hon. ROMANO L. MAZZOLI,
Chairman, Subcommittee on Labor, Social Services and the International Community, Committee on District of Columbia, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN MAZZOLI: On behalf of the American Medical Association, I would like to submit for your consideration our comments on H.R. 11108 and H.R. 11535, which we understand are now under consideration by the Subcommittee on Labor, Social Services and the International Community. This legislation would extend for three years the District of Columbia Medical and Dental Manpower Act of 1970 which authorizes assistance to the private non-profit medical and dental schools in the District of Columbia.

The Association has long stressed the importance of the Nation's medical schools and their needs for adequate financial support from diverse sources if they are to continue to perform their essential functions in society of preparing competent practitioners of medicine to provide timely and effective medical services to the American people.

Among the important sources of funds for medical education have been those from the States. In many States privately supported as well as publicly sup-

ported medical schools receive financial support from States to assist the schools in carrying out their education of medical students. In a sense, the District of Columbia bears the same relationship to the private medical schools within its borders that States do to the private medical schools within theirs.

The American Medical Association would therefore support H.R. 11108 and H.R. 11535 to authorize such assistance to the private medical schools in the District of Columbia. However, since it is most important that all of the nation's medical schools continue to receive adequate financial support, funds made available through this legislation should not diminish the availability of Federal funds for medical schools throughout the nation and for which all such schools are eligible to compete.

Thank you for this opportunity to present these views. I respectfully request that this letter be made part of the record of your hearings on H.R. 11108 and H.R. 11535.

Sincerely,

ERNEST B. HOWARD, M.D.

STATEMENT OF DR. ROBERT E. CLEARY, PROVOST OF THE AMERICAN UNIVERSITY,
REGARDING HR 11108, A BILL TO EXTEND FOR THREE YEARS THE DISTRICT OF
COLUMBIA MEDICAL AND DENTAL MANPOWER ACT OF 1970

This statement is submitted on the occasion of the hearings on the proposed extension of the District of Columbia Medical and Dental Manpower Act of 1970 to endorse the principle of extending this act to include schools of nursing attached to universities in the District of Columbia.

The Chairman and Members of the Committee know that private universities in the District of Columbia are uniquely disadvantaged financially because they are not located in a state and are therefore not eligible for state aid. The District of Columbia is not now in a position and for the foreseeable future will probably not be in a position to finance what in essence would be state aid.

In the Medical and Dental Manpower Act of 1970 the Congress recognized a federal obligation and opportunity to assist private nonprofit medical and dental schools in the District of Columbia in their critical financial needs to maintain their quality medical educational programs and to increase the number of students in such institution as a necessary health manpower service to the District of Columbia. The current focus for the renewal of the Act offers the opportunity to expand its scope to a related and equally vital aspect of medical educational programs—schools of nursing.

Quality education and training of nurses, and for that matter of all professional and para-professional medical personnel, is critically essential to the health manpower service needs of the District. If sufficient funds can be authorized and appropriated to include schools of nursing in the extension of the District of Columbia Medical and Dental Act of 1970 the Congress can take another important forward step to assist educational institutional nursing schools in meeting their critical financial operational cost needs to sustain their quality programs and to increase the number of nursing students as a necessary health manpower service to the District of Columbia and its metropolitan area.

Schools of Nursing in the District of Columbia are seriously underfinanced. While small, the Lucy Webb Hayes School of The American University offers a concrete example of this situation. The School has an income of approximately \$125,000 in the current 1973-1974 academic year. The students of the School will pay approximately \$100,000 in tuition and about \$25,000 is earned on the School's endowment each year.

The direct costs of the School—including about \$125,000 in faculty salaries—are approximately \$185,000 this year. Because The American University does not allocate space costs, utility costs, office operating expenses, and other overhead charge to the School of Nursing and to the other schools of the University, only about 50% of the total cost of operating the University appears in the School budgets. Thus the School of Nursing's fair share of the University's operating costs is another \$185,000. Depending on what figure is used, therefore, the operating deficit of The American University's School of Nursing for 1973-1974 is \$60,000 to \$245,000, and—fairly stated—closer to the higher figure. As a result the continued existence of the School is in jeopardy. Any assistance that could be provided by a broadening of the Medical and Dental Manpower Act of 1970 to include nursing schools would help assure the School's needed continuation and enhance the health manpower service objectives of the Act.

ROBERT E. CLEARY.

GEORGETOWN UNIVERSITY COMMUNITY HEALTH PLAN,
Washington, D.C., January 23, 1974.

Re H.R. 11108.

HON. ROMANO L. MAZZOLI,

Chairman, Labor-Social Services and the International Community Subcommittee, House District Committee, U.S. Congress, Washington, D.C.

DEAR CONGRESSMAN MAZZOLI: I understand that the House District Committee will soon be considering the Medical-Dental Manpower Bill, HR 11108, which would enable the George Washington and Georgetown University Medical Schools and the Georgetown Dental School to meet their deficits. Passage of this Bill has strong implications for the continued operation of the Northeast-Georgetown Medical Center (NEGMC).

The NEGMC is the urban branch of the Georgetown University Community Health Plan (GUHP). A brainchild of the Georgetown University School of Medicine, this facility is, in effect, a project in demonstration of an across-the-board attack on many of the problems which beset our medical care system. As Health Services Director of this facility, I feel quite qualified to discuss its many aspects.

There is universal agreement that the cost of medical care is high and it continues to rise. GUHP has attacked this problem by organizing our services around a prepaid group practice. Past history has shown that this method of delivery results in substantial savings and our experience thus far is bearing this out.

At the NEGMC, we are servicing a variety of plans, including regular Blue Cross and Medicaid. Members of these plans have constant accessibility to our Center, 24 hours a day, 365 days a year. We provide outpatient services, hospital services, extended care services, home health services, mental health services—in short, the gamut of services relatively unavailable to the average family. The fact that we are a group practice, our university connection, and our quality review mechanisms, ensure a high standard of care.

It is also generally agreed that there is a manpower problem. At the physician end, the Georgetown University School of Medicine is presently accepting more than two-hundred (200) freshmen medical students per year. I am acutely aware of this as a member of the Admissions Committee of the institution which is forced to turn away more than eight-thousand (8000) applicants per year from all corners of the nation. At the NEGMC our primary care physicians are ably assisted by a physician assistant and we are presently training nurse practitioners. Our goal is that nothing should be done by physicians that does not have to be done by physicians. Hopefully, when the service component is fully developed we could, at the behest of our community board, not only train more of these physicians extenders, but help to produce physicians who would see their responsibility not only to the patients under their care but to the community on the whole. These are our educational goals.

Finally, through our University affiliation, we have also embarked upon several workable projects. Our Nutrition Program is geared towards bringing what is already accepted in nutrition research to our community. This program tackles obesity, hypertension, diabetes mellitus and iron deficiency anemia, at the ground level. As you know, these diseases are of high incidence in the community, and have a strong connection with our poor nutrition. Our Health Education Course is geared toward providing the community with a better understanding of their health problems with the view that this would lead to better utilization of health services. Our relationship with our community board has been a good one.

I urge you, as chairman of the Labor-Social Services and the International Community Subcommittee, to continue the funding of these institutions, so that we out here in the inner-city could continue playing our role not only as a provider of medical services to the Northeast Washington Community, but also continue to be a potential source of medical manpower which could be used both at the local and national levels.

Sincerely,

KENWYN H. NICHOLLS, M.D., MPH,
*Health Services Director,
Northeast-Georgetown Medical Center.*

AREA C POLICY BOARD,
Washington, D.C., January 24, 1974.

To: The Honorable Congressman Mazzoli.

Re: Appropriations per student to support Basic Medical Education.

We are the Area C Policy Board of D.C., made up mainly of users of Health Services, both public and private. We are asking that the following statement be made a part of the Record of Hearings to be held on January 24, 1974 since we will be unable to appear.

We are working to help improve Health Care Services in the District and are appalled at the cut-back in services (due largely to shortages of staff) to the Inner City Residents. This further increases such statistics as non-white infant mortality rate percent not immunized, percent that have anemia, etc. The cut-backs almost ensure the failure of *Preventative* Health Care. We feel that any monies being considered for appropriation in the District, priority wise, should be earmarked to upgrade services to D.C. residents. We feel strongly in this matter and as a result raise the following questions:

1. Why are there so little funds for training and continuing for Health and Mental Health workers?
2. Why should the Public pay for Doctor training and then later be fleeced by the Profit Motive?
3. Why should the Public support Graduates of whom only 8% remain in D.C. and Schools that enroll only 5% of D.C. residents?
4. Why is the para-professional training limited to a small Physician Assistant Program?
5. Why is George Washington Medical School leaving D.C. General Hospital? Is this because of HMO? Where is their concern for those unable to pay?
6. How does this bill affect District Problems? Will this subtract from the already strained D.C. Budget?
7. Who will evaluate level of care?
8. What have these two schools done to improve and upgrade Health Care in the District?

We again wish to *emphasize* that any manpower funds be given to the District for training and continuing education of D.C. Residents which in turn will begin to upgrade the level of care for D.C. Residents.

VERONICA BROWNE,
For the Board.

THE GEORGE WASHINGTON UNIVERSITY,
Washington, D.C., February 7, 1974.

HON. ROMANO L. MAZZOLI,
Chairman, Subcommittee on Labor, Social Services and the International Community, Committee on the District of Columbia, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN MAZZOLI: The enclosures are in response to a request from your office through Mr. J. D. Kirschten regarding the accusation that "George Washington University has pulled out of D.C. General Hospital". In this material I have highlighted phraseology which would be of particular interest to you and your Committee.

George Washington University did not "pull out of D.C. General Hospital" but rather agreed to cooperate in a new arrangement which would improve the delivery of health care at D.C. General Hospital and, possibly, through increased efficiency, reduce the overall cost of delivering care at that institution. Although it was recognized by all three universities and by the District of Columbia Government that a one to one relationship at D.C. General would be best for that institution, no one university was prepared to undertake this total responsibility. It is of significance that many municipal hospitals throughout the country have been facing the same problem. For example, Boston City Hospital, which for generations has been operating under the aegis of the three medical schools in Boston, has within the past year been turned over to Boston University as a single responsibility. Both Harvard and Tufts are no longer participating in the programs of Boston City Hospital.

Because of George Washington University's heavy commitment to other inner city obligations and its relatively minimal involvement at D.C. General Hospital, it was mutually agreed among the three universities and endorsed by the Director of the Department of Human Resources that beginning July 1, 1974, the D.C. General Hospital would be affiliated only with Georgetown University and Howard University.

In the enclosed letter of August 24, 1973, addressed to me from Joseph P. Yeldell you will note that he commends George Washington University for its years of outstanding service at D.C. General Hospital and states that he looks "forward to a continuing relationship in the many other areas of health care delivery". As Mr. Yeldell indicated, George Washington University intends, as in the past, to respond to the mandate referred to by Mr. Yeldell.

Rather than to go in to more detail, I respectfully refer you to the historical record contained in the enclosed correspondence. If more information is required, please do not hesitate to call upon me.

With best wishes,

Sincerely,

JAMES J. FEFFER, M.D.,
Vice President for Medical Affairs.

(Enclosure)

HOWARD UNIVERSITY,
THE GEORGE WASHINGTON UNIVERSITY,
GEORGETOWN UNIVERSITY,

Washington, D.C., June 29, 1973.

Hon. JOSEPH P. YELDELL,
Director, Department of Human Resources,
Washington, D.C.

DEAR MR. YELDELL: On August 17, 1972, you and your colleagues met with the then Deans of our three Medical schools, James J. Feller, M.D., Marion Mann, M.D., Ph.D., and John C. Rose, M.D., and proposed that there be accomplished a consolidation of the several services at D.C. General Hospital. Those services currently operate as collaborative but separate, university identified units. (The occasion of that meeting was your approval of an Area Health Education Center proposal which was being submitted by the three medical schools in collaboration to the National Institutes of Health).

On September 15, 1972, a letter was sent to you jointly signed by us, the Health Sciences Vice Presidents of The George Washington University, Howard University and Georgetown University. That letter expressed the unanimous agreement of the universities "that the subject of consolidation of services should be studied in a comprehensive and scientific manner, and with a sense of urgency and commitment to the direction in which our analysis points."

That letter described also the approach to be used in the study of this problem, suggesting committees that would study, evaluate and recommend regarding the financial commitments, academic considerations and services to patient functions for both the inpatient and the ambulatory services. While we received no answer to our letter from your office, we were subsequently able to ascertain that you were aware of our activities and approved of the methodology suggested. Dr. Dunmore advised us on several occasions of your continuing interest with regard to the important problems that we were considering. Though the pressure of his work prevented his attendance at the meeting, Dr. Dunmore was a member of the committee and invited to all of the meetings.

A series of meetings ensued during the fall, winter and early spring of the current academic year, with wide ranging representation from the three universities and D.C. General Hospital. You and your colleagues would be gratified at the enthusiasm with which the administrative officials, department heads and D.C. General medical staff representatives approached these vital issues. It was apparent that the four institutions involved have the same service and educational objectives and interest and that it would be possible to work towards a constructive analysis of the educational and patient care programs at D.C. General Hospital.

FINANCE

The expenditures of the three universities at D.C. General Hospital during 1972-73 are summarized on the attached Schedule I. These expenditures have been verified and back up data can be presented if necessary. Schedule I does not include any information taken from the annual budget of D.C. General Hospital.

It is certainly not the intent of Schedule I to suggest that this level of expenditure is entirely for patient care. We are agreed that the primary purpose of the medical schools and dental schools at D.C. General Hospital is to provide resources and supervision at D.C. General Hospital for the more effective education of the wide variety of trainees located there, the end result being a higher quality of patient care. Faculty spend their hours rendering patient services in a manner that is overlapping and intertwined with their activities as educators and investigators performing biomedical research.

It should not come as news to you that there is a greatly heightened cost consciousness at our three universities. There have been extreme federal funding cutbacks in the support of biomedical research and in the support for medical and dental education. Several of us are involved in detailed cost allocation studies sponsored by the Bureau of Health Manpower of NIH, the Association of American Medical Colleges and the Institute of Medicine of the National Academy of Sciences.

The three universities are continuing to struggle with the problem of identifying the true cost of medical education and the fiscal impact on our institutions of research and patient service programs. These comments should be very directly construed as meaning that the universities will be hard pressed to maintain the level of present support and surely will not have additional financial resources to invest in programs at D.C. General Hospital.

As can be seen from Schedule I, a total of \$2,285,014 (Howard University \$876,989; George Washington University \$268,019; and Georgetown University \$1,140,006) from three universities in these increasingly difficult times is an allocation of resources beyond the capability of the universities but yet a demonstration of dedication and commitment to the community of Washington, D.C. When losses experienced by the university hospitals under the medical charities program; other losses for health care of the indigent and medically indigent and the financial support of inner city HMO's are added, the total commitment of our universities to the community in which we are proud to serve, becomes a considerable manpower and financial investment. In these times of diminishing support to university health science centers, the three Washington, D.C., University Medical Centers need all of the support and encouragement possible, so that the institutions may continue viable and of service to the community and the nation.

At a recent meeting of the Board at D.C. General Hospital, we advised Dr. Dunmore that, in presenting the total financial picture of D.C. General Hospital, he should include the funds expended at the Hospital by the three universities, in addition to funding provided through Congress and the Government of the District of Columbia. Dr. Dunmore said that he would be pleased to do this when detailed statements (Attachments) were made available to him by the three universities.

A study of Schedule I and an analysis of the program as conducted by the three universities would indicate that no reduction in these costs can be anticipated if the services at D.C. General Hospital were to become completely unified in any sense. Given the same patient census, just as many beds will be needed. A study of equipment and its use indicates clearly that in instances where large numbers of patients require the same type of technologic or equipmental support, multiples of such equipment would continue to be needed, whether these be one university or three universities.

A sampling of several different items of duplicated patient care ward equipment verified the need for duplication in the best interest of the patient. Furthermore, such items of equipment are a one-time expense, constitute a minute portion of the budget and of themselves offer little opportunity for significant saving, even if some patients were to be deprived of availability.

It has been pointed out in our analysis that the appointment of another layer of administration-coordination is certain to add considerably to the direct and indirect costs in the D.C. General Hospital budgets.

ACADEMIC CONSIDERATIONS

Twelve department chairmen in the three medical schools responded completely and enthusiastically to a series of questions concerning unification of services. With the exception of one hedged reply of the 12, there was a strong support for the continuing school identity of each of the services conducted at the hospital. It was recognized that there could be better cooperation and coordination, and attempts to achieve this are already underway. Detailed responses of each of the department chairmen are available for your inspection. It was generally agreed that two schools would be better than three in relation to the medical and surgical services. There have been discussions, as described hereafter, as to how this consolidation can best be accomplished.

PATIENT SERVICES

The predominant opinion of the medical staff at D.C. General as well as the faculty of the universities is that total unification, by blurring university identification, will jeopardize physician recruitment and university support. Patient care, already marginal in some areas, will deteriorate grossly if staff and resources shrink. As that committee reported, "the present system, warts and all, may be a safer choice than a speculative reform which might, in fact, cause great mischief." The committee recommended that the medical and surgical services retain the present autonomous divisions. It was agreed that universally, "super chiefs," or medicine and surgery will disappoint, do not function effectively and detract from, rather than contribute to patient care. The clinical services would be better coordinated by a Medical Director, appointed by the Executive Director, with the advice and consent of the universities.

TWO UNIVERSITIES INSTEAD OF THREE

After careful review of university-public teaching hospital arrangements in several parts of the country and past experience at D.C. General Hospital, the study committee concluded that the educational and patient care objectives of the affiliation could be realized more effectively by involvement of fewer administrative units. The ideal arrangement would be a one-to-one relationship between a university and D.C. General Hospital. However, there was agreement that at this time no one university was prepared to undertake a single relationship.

Since the George Washington University is only minimally involved at D.C. General Hospital at the present time and is already heavily committed to other inner city obligations, it was mutually agreed by the three universities, that Georgetown and Howard Universities, with the approval of the Department of Human Resources of the District of Columbia, would undertake the total patient care and teaching responsibilities at D.C. General Hospital.

The committee noted that if accomplishment is the objective, it is first necessary to establish a firm implementation date of this plan, preferably not later than August 1, 1973. Formal, specific commitments must be determined as to the services to be conducted by Georgetown and Howard Universities. Considerable lead time is essential for appropriate faculty and house staff recruitment.

Although the changes here recommended will have the effect of providing more efficient operation of both clinical services and educational programs, it is clear that there will not be an associated reduction in cost. Actually for the two Universities remaining at D.C. General Hospital (if this plan is accepted) the undertaking of additional responsibility will necessitate full financial support from the District of Columbia. In these times of reducing federal and other support to medical and dental education, the resources of both Universities are being strained to the utmost. Howard University expends \$876,989 annually and Georgetown University expends \$1,140,006 annually at D.C. General Hospital.

This letter summarized our discussions and conclusions concerning possible consolidation of services at D.C. General Hospital. It has been a fruitful exercise. We believe the recommendations are valid, significant, and if implemented of importance to continued input in patient service for the citizens of Washington,

D.C. We urge your early and favorable consideration. We are prepared to meet, discuss, conclude concerning objectives and then evolve the details of accomplishment. We look forward to your response.

Sincerely,

CARLTON P. ALEXIS, M.D.,
Vice President for Health Affairs,
Howard University.

JAMES J. FEFFER, M.D.,
Vice President for Medical Center Affairs,
George Washington School of Medicine and Health Sciences.

MATTHEW F. McNULTY, Jr., Sc.D.,
Executive Vice President for Medical Center Affairs,
Georgetown University.

Attachments.

(Enclosure)

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
DEPARTMENT OF HUMAN RESOURCES,
Washington, D.C., August 24, 1973.

JAMES J. FEFFER, M.D.,
Vice President for Medical Center Affairs, George Washington School of Medicine and Health Sciences, Washington, D.C.

DEAR SIR: Your letter of June 29, 1973 has been received and reviewed. I would like to take this opportunity to express my deep appreciation for the manner in which the three universities approached the task involved, the in-depth assessment of the issues and the recommendations finally developed.

As you know, the primary issue of consolidation of the several services at D.C. General Hospital currently provided by three separate programs has been before us for a long time. Your agreement to conduct an analysis of the program as it currently exists and to develop recommendations with respect to future direction have come at a most propitious time for the Department.

The areas of financial participation and academic prerogatives, collaboration and cooperation have apparently been addressed in a very forthright and candid manner. Unification of services certainly bring economies and efficiencies that heretofore have not been possible. The recommendation that the medical and surgical services retain current autonomous divisions would not appear to compromise the spirit of the charge extended with respect to the goals and objectives previously delineated. With the executive director being a medical doctor, I can see no need for the appointment of a medical director at this time; however, this particular item should and will be under constant review. At the point where we mutually agree to the need for such a position. I assure you that the selection will by all means be with the advice and consent of the universities.

You indicated general agreement that the hospital/university teaching mission can perhaps be more effectively conducted through fewer administrative units. Further, a consensus conveyed that at this time no one university is prepared to assume full responsibilities in this area. Accordingly, I concur with the assumption of joint responsibilities on the part of Georgetown and Howard Universities with respect to total patient care and teaching requirements at D.C. General Hospital, effective July 1, 1974.

The decision of George Washington University to relinquish its participation in the program at D.C. General Hospital is, of course, without prejudice on the part of the University or the Department of Human Resources. As a member of fact, it is, indeed, most appropriate that we commend George Washington University for its years of outstanding service at D.C. General Hospital. We look forward to a continuing relationship in the many other areas of health care delivery. Further, we will be counting on the University just as in the past, as the needs of the city mandate close cooperation and coordination continually.

Again, I would like to extend my thanks to you for the sustained effort and time you expended in conducting the reviews and performing the analysis and recommendations conveyed in your letter.

Sincerely,

JOSEPH P. YELDELL, *Director.*

(Enclosure)

GEORGETOWN UNIVERSITY MEDICAL CENTER,
Washington, D.C., August 31, 1973.

Hon. JOSEPH P. YELDELL,
Director, Department of Human Resources,
Washington, D.C.

DEAR MR. YELDELL: Your letter of August 24 was thoughtful and thorough. Thank you for such a careful review.

Howard University and Georgetown University are now implementing plans for joint responsibility of the teaching patient care program at D.C. General Hospital effective July 1, 1974. Recruitment has been initiated and several individuals in advanced House Staff roles are already committed for 1974.

As you know though July 1, 1974, is only ten months away, it is already late in the recruitment year (except for the matching plan application) so that judicious speed is desirable if not essential. However, these efforts will be carried out in unison by our colleagues from Howard and Georgetown Universities at D.C. General Hospital.

We may have a difference of opinion with what we regard as sufficient span of important work to entail a need for both an Executive Director (regardless of discipline preparation) and a Medical Director (M.D.). However, we agree that the best method of resolution is to review the operation carefully with continuing evaluation.

We, of course, join you in commending George Washington University for the years of outstanding service rendered by our colleagues from that University. It is the intent of the three universities to continue our Academic Health Science Consortium for the three universities are involved jointly in several community projects. We anticipate that other opportunities of service will arise in the future to which, in the interest of the community, we can better address ourselves jointly.

It is important to note that over the years all three universities have contributed significant institutional resources (hard dollars) to each of our endeavors at D.C. General. In the period of more sufficient federal funding for quality research and demonstration projects, it was possible for each of the universities to contribute manpower and other support. Now with even the most widely acclaimed research grant applications being approved with high priority but not funded, every university health science center in the country is engaged in very vigorous but necessary retrenchment.

Information available in the public press and through the informed "professional publications" indicates that the situation will not improve. It is therefore important that the representatives from Howard and Georgetown Universities work closely with the Executive Director of D.C. General Hospital and follow through to provide fully for the financing of the manpower, supplies equipment, et cetera needs at D.C. General Hospital.

The work of review, evaluation and recommendation as eventually outlined in our letter of June 29, was the effort over many months of colleagues from the three academic health science centers working together cooperatively and harmoniously. I shall indicate to them your expressions of appreciation.

Thank you and continued best wishes.

Cordially,

MATTHEW F. McNULTY, JR., Sc.D.,
Executive Vice President for Medical Center Affairs.

(Enclosure)

THE GEORGE WASHINGTON UNIVERSITY,
Washington, D.C., September 18, 1973.

Hon. JOSEPH P. YELDELL,
Director, Department of Human Resources,
Washington, D.C.

DEAR MR. YELDELL: I am most grateful for your very considerate letter of August 24, 1973. I am convinced that your decision will be for the good of D.C. General Hospital as well as for the residents of this great City. I can assure you of George Washington University's intention to remain actively involved in all the health care problems of the District of Columbia, and I hope you will feel free to call upon us when new opportunities arise for us to be of assistance.

We fully recognize our community responsibility to the D.C. General Hospital and would appreciate the opportunity to continue to be represented on the new Advisory Board.

Again, my deep appreciation for your understanding.

With warm regards.

Sincerely,

JAMES J. FEFFER, M.D.,
Vice President for Medical Affairs.

(Enclosure)

OCTOBER 31, 1973.

JAMES J. FEFFER, M.D.,
Vice President for Medical Affairs,
The George Washington University,
Washington, D.C.

DEAR DR. FEFFER: Thank you for your letter of September 18, 1973 in which you express recognition of George Washington University's community responsibilities to D.C. General Hospital. As indicated earlier, the University's relationship with D.C. General Hospital has been of estimable value to the overall health thrust of the District of Columbia. I wish to reaffirm the expectation of continued participation in other areas of health care activities after conclusion of the University's relationship with D.C. General Hospital.

Your request for representation on the new D.C. General Hospital Advisory Board is acknowledged and will be given full attention during the selection process. May I again extend my personal thanks and that of the City for your interest and participation in the health care programs of the City.

Sincerely,

JOSEPH P. YELDELL,

FEDERAL CITY COLLEGE,
NATURAL SCIENCE DIVISION,
Washington, D.C., February 11, 1974.

Congressman ROMANO MAZZOLI,
Chairman, Subcommittee on Labor, Social Service, and the International Community, Committee on the District of Columbia, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN MAZZOLI: It was a pleasure to testify before your committee in the hearing on the DC Medical/Dental Manpower Act extension and I considered it a privilege to do so.

Enclosed is a list of students from Federal City College who have entered the various medical, dental or biomedical graduate programs. I am very proud and happy to indicate that all students who have entered the various programs are continuing in those programs and have not contributed to the attrition statistics.

Enclosed is also the data for DC residents in Georgetown and George Washington Medical Schools and the number of women and minorities in these schools over the last 3 years. This data was obtained from Assoc. Amer. Med. Colleges.

If there is any other information that you or your committee would like to have, please do not hesitate to contact me.

With best regards, thank you again.

Sincerely yours,

VIJAYA L. MELNICK, Ph. D.,
Assistant Professor and Premed Adviser.

Federal City College students in medical and dental schools (by entering freshman class of the listed schools).

1971-72

Univ. of Ohio Medical School—1.
Temple Univ. Medical School—1.

1972-73

Howard Medical School—1.
Howard Dental School—1.
New Jersey Medical School—1.

1973-74

Rutgers Medical School—1.
 Downstate Medical School, N.Y.—1.
 Meharry Medical School—1.
 Univ. of Miss. Medical School—1.
 Jamaica Medical School—1.
 George Washington Medical School—1.

1974-75

Univ. of Penn Medical School—1.
 New York Univ. Dental School—1.

(List is incomplete, since students are being considered currently.)

All of these students had applied to either or both Georgetown and George Washington Medical Schools.

In addition we have students in the Bio-medical graduate programs at such places as State Univ. New York, Stoney Brook; Howard University; Univ. of Calif. Veterinary School, Davis; American University; and George Washington.

Our students also successfully completed summer school or research programs in such institutions as Harvard University, Univ. of Tenn-Oak Ridge Natl Lab, Bio. med program and Meharry Medical School.

<i>Georgetown</i>		<i>Total number entering</i>
1971	-----	213
District of Columbia residents	-----	11
Women	-----	31
Black	-----	13
Mexican American	-----	1
Oriental	-----	3
1972	-----	213
Women	-----	34
Black	-----	10
Puerto Rican	-----	2
1973	-----	210
Women	-----	37
Black	-----	8
American Oriental	-----	2
<i>George Washington</i>		<i>Total number entering</i>
1971	-----	128
District of Columbia residents	-----	11
Women	-----	17
Black	-----	5
Oriental	-----	4
1972	-----	143
Women	-----	25
Black	-----	3
American Oriental	-----	3
1973	-----	153
Women	-----	37
Black	-----	6
American Oriental	-----	3

Source : Above data received from Association of American Medical Schools.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., February 22, 1974.

HON. ROMANO L. MAZZOLI,

Chairman, Subcommittee on Labor, Social Services and the International Community of the Committee on the District of Columbia, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: During our meeting with representatives of George Washington University and Georgetown University on February 7, 1974, you requested more specific data resulting from our review of the financial distress applications made by these schools. I think you will find the enclosed statement responsive to that request.

The statement was originally prepared for delivery at our February 7 meeting. The statement was not read since as the meeting evolved I felt that an informal exchange was more appropriate. However, I feel that the points made in the introductory portion of the statement are worth making and tend to place our substantive comments regarding the administration of these schools in a clearer context.

I am also enclosing three additional documents which you asked for. The first is a copy of the AAMC summary of State roles in the financing of medical education, including data on State aid to private institutions. Additionally, the last two documents are copies of the official letters sent to George Washington University and Georgetown University notifying them of action taken on their fiscal year 1973 financial distress applications.

We appreciate the opportunities you have given us to present our position on H.R. 11108. If I can be of any further assistance, do not hesitate to call me.

Sincerely yours,

JOHN S. ZAPP, D.D.S.

Deputy Assistant Secretary for Legislation (Health).

Enclosures.

STATEMENT REQUESTED BY REPRESENTATIVE MAZZOLI REGARDING THE ADMINISTRATION OF PRIVATE MEDICAL AND DENTAL SCHOOLS IN THE DISTRICT OF COLUMBIA

In the course of presenting testimony before the subcommittee of Labor, Social Services and International Community Committee of the District of Columbia regarding H.R. 11108 reference was made by the DHEW representatives to deficiencies of the administration of the institutions in question. Specifically, it was stated that, "The Department is of the view that, in general, the prolonged period of financial uncertainty experienced by these schools . . . the end of which is not yet in sight . . . reflects a serious deficiency in the administration of these institutions. For instance, the schools have not followed the common practice in other medical schools of instituting a viable intramural faculty practice plan to assure that some reasonable portion of the financial resources generated by certain of the clinical departments is applied toward keeping the other departments of the school on a sound financial footing. George Washington Medical School has given some thought to trying to reform its policies in this regard and may be in a position to stabilize its finances in the not too distant future. The Georgetown schools, however, have thus far not moved to implement long overdue management reforms to an extent that would correct their financial difficulties."

Subsequent to this, it is our understanding that officers of the two universities stated to the committee that they are not aware of any alleged deficiencies or of any changes suggested by your department (DHEW) which have gone unheeded. A spokesman for George Washington University said, "his medical center had pioneered in the development of a plan for pooling faculty fees."

On this basis the committee chairman Hon. Romano Mazzoli invited representatives of DHEW and the institutions in question to his office for a discussion and expressed the expectation that documentation of any deficiencies in management or administration be made available.

We welcome the opportunity to discuss these matters in a constructive spirit and to this end are providing additional background material pertinent to some of the aspects of our concern.

In the first instance, we recognize that the statement as quoted from our testimony (cf. above) may appear unduly harsh, judgmental and simplistic since it was not accompanied by adequate explanation and dealt with a most complicated and difficult matter.

It should be understood by the committee and the institutions that our concern has a *realistic basis*. These institutions have applied for financial assistance because of need every year since 1968. During the last (3) years this application was made under the financial distress program. During these three years the applications have been intensively reviewed by expert consultants drawn almost exclusively from experienced medical center administrators and financial management personnel of such institutions. In two (2) of these years the applications received additional evaluation by special review committees whose membership was largely drawn from the rolls of professional school administrators and academicians. Lastly the Advisory Council on Health Professions Education has reviewed and acted on the applications. *Every year, at all levels* and by virtually *all outside consultants criticism and concern* have been voiced about various aspects of their operation. The outside expert consultants have usually recommended disapproval or expressed uncertainty because of confusion in the data supplied. The review committees recommended disapproval in two of the prior years. (There is no review committee this year because of a change in the system occasioned by increased regional office participation.) Last year (1973), the advisory council actually disapproved the applications in toto on the first action. Later they reversed this action after special reconsideration. They finally recommended funding at a reduced level.

The criticisms and concerns have varied from year to year and from institution to institution. In the earlier years of the financial distress program DHEW had great difficulty obtaining data which was internally consistent and understandable. Sometime studies initiated or designed by outside groups such as the AAEC cost study generated data which appeared inconsistent with the financial statements submitted by the school. The administrators were responsive to this frustrating situation. Dr. McNulty of Georgetown University and Dr. Feffer of George Washington are to be commended for a significant improvement in the data supplied to DHEW. Despite these improvements there always remain areas requiring clarification. The precise details of the faculty practice arrangements at Georgetown University is one such area.

It is our purpose at this point to present highlights of the principal criticisms and concerns, school by school, for the current round of application review. It should be borne in mind that reviewers have looked at the applications from the standpoint of the financial distress legislation. This includes the view that it was the intent of Congress to eliminate financial distress over a three (3) year period and enjoined all of the applicants to present such a plan.

GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

The following are excerpts from the reports of consultants and staff reviewers:

"This application reflects little progress in improving practices which have concerned reviewers in the past two years. Among these are (1) Continuance of the apparently arbitrary 60-40 percent allocation of costs in the basic science departments to the medical and dental schools. (2) Lack of information regarding the school's clinical practice plan. (3) No indication of considerations of actions to reduce costs when necessary through reduction or elimination of program or activities and other actions to contain or reduce costs. (4) continued program expansion, in some cases substantial. (5) continuance by the school of the contentions that in the absence of federal support the University Board of Directors will have to consider relinquishing control of the school with no satisfactory explanation of what this means, and (6) treatment of unapplied gifts as assets rather than income."

Two reviewers commented on the substantial percentage increase in the Department of Community Medicine and International Health, the Department of Biophysics-Physiology, and the Dean's Office as indicating continued program expansion. "Faculty salary expenses are slated for a 12% increase while the number of students increased only 7.5%." One reviewer commented as follows: "My observations would indicate the lack of any substantial effort to increase the income from endowment and investment or gifts while at the same time making

little effort to control salary increases or staffing." The same reviewer asks "Why there is so little increase in sponsored programs and Faculty Medicine Services?" "Why is there no allocation of University surpluses to this condition of distress?"

In summary, concern has been clearly expressed by the reviewers because there is little evidence of effective cost containment and/or activities leading to expanding income. Some concluded that there is undue emphasis on additional federal funding as the only alternative. DHEW expresses disappointment that the administration of this school has not designed and/or implemented an effective plan during the last three years which would reduce costs and/or expand income such that balance in its operations is within sight.

GEORGETOWN UNIVERSITY SCHOOL OF DENTISTRY

The following are excerpts from reviewers of this application :

"Aside from certain specific information this application is the same as submitted by their sister school of Medicine . . . the majority of my comments made in the Medical School report are also applicable here. . . . Like the Medical School the applicant points to numerous increases over which they have little control. A number of these have been initiated by the University. . . . With financial distress support over the past years the University has not given any support and none is projected for this or future years. . . . Little is included in the application to indicate the School's consideration of alternate potential sources of income. . . . Their fund raising has not been good and they indicate very little commitment to improving their present . . . practice plan. . . . They have stopped efforts toward cost reduction because their Executive Faculty concluded that "further reductions would so adversely affect the quality of education that accreditation would be seriously threatened." Other reviewers echo comments above expanding the Dental Clinic income, more vigorous fund raising and some help from the parent university. There is reference by all reviewers that no plan has been presented to eliminate or substantially reduce the imbalance except obtaining additional federal assistance."

In summary, the reviewers were concerned by the lack of a plan which addressed itself to cost containment and/or expansion of income with particular reference to Dental Clinic income and fund raising.

GEORGE WASHINGTON SCHOOL OF MEDICINE

The following are excerpts from reviewers :

"The record of funding of operating needs for this private D.C. Medical School totals \$5,297,600 over the 3-year period, and this year's application will require an additional \$2,782,210 for deficit, the largest request made by the institution under the program. In fact, the earlier projections of operating deficit made by the institution fall under the deficit projected now. In short, the institution goes nowhere in resolving this matter except in a circle of deeper difficulty. * * * The institution has realigned management, revised its budget and operating procedures to program oriented purposes, imposed ceilings on spending, position control, and instituted a wage and salary compensation program. The management effort is sincere and certainly one that is changing the life style in the institution. It is, nonetheless, to little avail in reversing the trend begun long before the distress fund mechanism. Last year the reviewers concluded that the applicant's actions were not as effective as might be expected, and the results were disappointing. The result this year is no better, in spite of additional management activities, ranging from reorganization with Center control, the tuition increase, to improved wage and salary management, and continuation of manpower freeze, to new funds for endowed chairs. In short, as management tightens its grip on areas of immediate concern, new problems arise with uncontrollable features to continue the high deficit trend. * * * The deficit is really programmatic in origin. Retrenchment must occur if the deficit is to be removed."

The view of another reviewer is as follows :

"Deficits projected through 1976-77 increase in total amounts each year but remain relatively static in terms of percentage of total expenses. The clear implication is an inability to curtail total expenditures in the face of huge expense increases. (20% of total). * * * Expenses as a result of expansion are substantial and continue to compound at a rate of roughly 20% a year. Faculty salaries will be up 18%; staff salaries, 11%; equipment will increase 7%; operation and maintenance of plant will increase by over 100%; and Medical

Center and university services will increase 15%. One may seriously question the magnitude of these increases in light of the programmatic increase and a period of financial distress. * * * In general, the increases are not unbelievable. *However, the increases do not speak to the issue of financial distress but rather to expansion despite financial distress.* * * * Plans to curtail expenses are modest. * * * One may be both critical and question the distribution of practice plan income which results in apparent positive balances in "Medical Center Appropriated and Unappropriated Funds." These balances were, according to the 1972-73 annual report of the university, \$1.6 million and \$2.9 million, respectively. The practice plan income is first applied as an offset to hospital losses. Balances remaining are transferred to the two funds mentioned before as well as an education and development and plant funds. The precise disposition of the fund balances derived from the professional practice plan is difficult to determine for the period in question. It is, however, evident that a substantial reserve exists which is operating as an endowment. These reserves have in the past and could presently be used to defray some of the current and projected deficits just as it has been used to defray the same short-falls in the hospital."

SCHOOLS IN FINANCIAL DISTRESS

DHEW has gained considerable experience with schools in financial distress since the implementation of this program. Many applicant schools were denied funds, some received reduced amounts and still others a full award. The actions taken by such schools have been impressive and include such drastic actions as terminating some existing faculty members, reducing faculty positions, reducing or eliminating faculty salary increases, gaining control of practice funds for general utilization, dipping into endowment funds, reducing or eliminating non-essential programs, putting community service programs on a self-sustaining basis, expanding alumni giving, deferring capital improvements and purchases, rescheduling educational programs to optimize faculty time, shifting costs to hospital budgets where appropriate, and seeking increased support of parent universities. In state schools it is usually not possible to budget a deficit. When legislatures do not expand support rapidly enough to offset loss of federal research and training funds or to offset increased costs it becomes mandatory to bring income and expenditures into balance. Whatever the circumstances, it is always a painful process since schools—their administration and faculty—are reluctant to reduce the scope and richness of their programs. We understand and sympathize with the efforts at Georgetown University Schools of Medicine and Dentistry and George Washington School of Medicine to maintain the diversity and range of their programs, to retain and attract faculty, in short continue at the present levels of academic excellence. We also recognize that the administrations of these schools have taken some steps in the direction of effecting economies. Nonetheless, other schools have managed to effect very significant changes without obvious harm in their undergraduate medical educational programs.

There are other private schools without state aid and limited reserves or with markedly restricted assistance which have "made a go of it" during these days of rising costs and fluctuating federal support.

In closing, we have attempted to present the background for the statement of 'deficiencies in administration.' We have highlighted the concerns of reviewers and placed their comments in the broader context of financially distressed schools. Obviously, we cannot and should not specify the precise steps these schools should take to bring their costs and revenues into balance. However, some approaches have been suggested.

FEBRUARY 28, 1973.

DR. JAMES J. FEEFER,

Associate Dean for Student and Curricular Affairs, The George Washington University School of Medicine, Washington, D.C.

DEAR DR. FEEFER: As requested in your telephone call of February 26, this letter provides an explanation of the action taken by the National Advisory Council on your financial distress grant request.

In recommending that the application be considered unacceptable, the Council appeared sympathetic to the unique circumstances surrounding D.C. schools and recognized the absence of state support. However, the Council was most concerned about the absence of an identifiable plan for reducing or eliminating fiscal deficits in future years, and could not identify definitive examples of

significant internal actions (in the Council's opinion) taken to reduce annual deficits. Concern was also expressed about the circumstances which permit the medical school to incur deficits while practicing income generated by salaried faculty is retained by the hospital. The Council also believed that there was no convincing evidence that failure to receive financial distress funds would cause the school to close, or to reduce the size of its medical class, or that the school's accreditation might be placed in jeopardy. For the above stated reasons the Council, therefore, concluded that the application did not adequately satisfy the guidelines for acceptability, or the intent of the financial distress legislation.

If you have any questions about the action, please feel free to contact us.

Sincerely yours,

HARRY W. BRUCE, Jr., D.D.S.,
Director, Division of Physician and
Health Professions Education.

FEBRUARY 28, 1973.

Dr. MATTHEW F. McNULTY,
Vice President for Medical Center Affairs,
Georgetown University, Washington, D.C.

DEAR DR. McNULTY: As requested in your telephone call of February 27, this letter provides an explanation of the action taken by the National Advisory Council on your financial distress grant request.

In recommending that the application be considered unacceptable, the Council appeared sympathetic to the unique circumstances surrounding D.C. schools and recognized the absence of state support. However, the Council was most concerned about the absence of an identifiable plan for reducing or eliminating fiscal deficits in future years, and could not identify definitive examples of significant internal actions (in the Council's opinion) taken to reduce annual deficits. The Council also believed that there was no convincing evidence that failure to receive financial distress funds would cause the school to close, or to reduce the size of its medical class, or that the school's accreditation might be placed in jeopardy. For the above stated reasons the Council, therefore, concluded that the application did not adequately satisfy the guidelines for acceptability, or the intent of the financial distress legislation.

If you have any questions about the action, please feel free to contact us.

Sincerely yours,

HARRY W. BRUCE, Jr., D.D.S.,
Director, Division of Physician and
Health Professions Education.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE.
Washington, D.C., March 11, 1974.

HON. CHARLES C. DIGGS, Jr.,
Chairman, Committee on the District of Columbia, House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of November 15, 1973, for a report on H.R. 11108, a bill "to extend for three years the District of Columbia Medical and Dental Manpower Act of 1970."

The District of Columbia Medical and Dental Manpower Act of 1970 (which was enacted as Title III of the District of Columbia Revenue Act of 1970) authorizes grants by the Secretary of Health, Education, and Welfare to the Commissioner of the District of Columbia, to assist private nonprofit medical and dental schools in the District of Columbia.

Grants may be made in amounts the Secretary determines to be the minimum amounts necessary to carry out the purposes of the Act, but in no event may such amounts exceed, in the case of a medical school, \$5,000 times the number of full-time medical students, or in the case of a dental school, \$3,000 times the number of full-time dental students enrolled. In determining the amounts of grants, the Secretary is required to take into consideration any grants to the respective District of Columbia schools under the Health Professions Educational Assistance authorities of Title VII of the Public Health Service Act relating to financial assistance to health professions schools in serious financial distress.

The District of Columbia Medical and Dental Manpower Act of 1970 expired June 30, 1972. This bill, H.R. 11108, would extend it for three years (fiscal years 1975 through 1977) and would authorize the appropriation of such sums as neces-

sary for carrying out its purpose. In effect, this bill would authorize the Secretary of Health, Education, and Welfare to assist private nonprofit medical and dental schools in the District of Columbia as some, but not all, States support private medical and dental schools located within a State's respective jurisdiction.

As indicated in our testimony before your Committee on January 24, 1974, the Department is opposed to a proposal which would single out schools in the District of Columbia and afford these schools preferential treatment for funding from the general revenues of the nation. Our position is that there are no overriding reasons of public policy to rationalize selecting out three District of Columbia medical and dental schools for special treatment as compared to the rest of the medical and dental schools in the nation. Assistance available through appropriations for the Department of Health, Education, and Welfare should be provided under terms and conditions which are applied nationally to all schools of medicine and dentistry throughout the nation.

We oppose providing special institutional support through appropriations to the Department of Health, Education, and Welfare. If such support is to be provided to these private schools within the District of Columbia, as it is provided by some States to private schools within their jurisdictions, we submit that this support should be provided by the District of Columbia Government. In this connection, we understand that the District Government is considering possible means of furnishing assistance to meet the District's health manpower needs.

The Administration's recommendations on the health manpower authorities, which are scheduled to expire on June 30, 1974, will soon be sent to the Congress. The need for continued special Federal financial assistance to the relatively small number of health professions schools still experiencing financial distress, and the terms and conditions under which such aid should be provided, are questions that must be addressed by the Congress on that legislation. We believe it would be inequitable and inappropriate for the Congress to legislate preferential treatment for the private schools in the District of Columbia without reference to the policies that will apply to the schools in the United States similarly situated.

For the above reasons, therefore, we recommend strongly against enactment of H.R. 11108.

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

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., February 24, 1974.

HON. CHARLES C. DIGGS, Jr.,
Chairman, Committee on the District of Columbia, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of November 15, 1973 for the views of this Office on H.R. 11108, a bill "To extend for three years the District of Columbia Medical and Dental Manpower Act of 1970."

In testimony before your Committee on January 24, 1974, the Department of Health, Education, and Welfare stated its reasons for recommending against enactment of H.R. 11108. Among other reasons the Department stated that it found no reason to single out three medical and dental schools in the United States for special treatment solely on the basis of their location within the District of Columbia.

We concur with the views expressed by the Department in its testimony. Accordingly, we recommend against enactment of H.R. 11108.

Sincerely,

WILFRED H. ROMMEL,
*Assistant Director for
Legislative Reference.*

GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE,
 GEORGETOWN UNIVERSITY SCHOOLS OF MEDICINE AND DENTISTRY,
 March 11, 1974.

HON. ROMANO L. MAZZOLI,
 HON. GILBERT GUDE,
 House of Representatives,
 Washington, D.C.

DEAR MR. MAZZOLI AND MR. GUDE: This is a brief response to the statement and documents of the Assistant Secretary of Health, Education and Welfare concerning the management of the Medical and Dental Schools at Georgetown University and the Medical School at George Washington University.

The continued need for financial distress is not due to mismanagement.

The report by the Association of American Medical Colleges concerning the ranking of Georgetown University shows that Georgetown's Medical School is second from the bottom out of twelve schools in terms of cost. This report was presented to you. George Washington School of Medicine is very similar in costs. The Georgetown Dental School has no such formal study but our own cost comparisons show it to be in the lower fifty percent of costs in comparing it with a group of similar dental schools.

In reference to the Assistant Secretary's statement that we have not taken significant steps to reduce costs, this we dispute. The average student cost has gone down as we have increased our enrollment.

In reference to the Assistant Secretary's statement that we are not obtaining outside funds, both Universities point to the millions of dollars raised from private sources for recently completed new medical school facilities. In addition, both Universities have separate active annual drives for support which generate large sums annually. We are striving to increase these amounts. Both Universities have large grant programs that are funded from private resources. These programs support a large part of the medical schools' costs.

In addition, all three schools successfully compete for federal grants for specific programs, though these federal programs are shrinking.

In reference to physician practice plans, George Washington University has a preeminent one that already supplies over a million dollars annually to support the Medical School. Facts about the plan are contained in their financial report to your committee.

Georgetown's Schools of Medicine and Dentistry have a physicians' practice plan under way. It aims to achieve what George Washington has already accomplished but time will be required to do this.

The Vice Presidents for Medical Affairs of both Universities will provide detailed separate reports to your office.

In Summary: The Medical Centers of both Universities control their costs by line item budget and income statements, which are reviewed by the Presidents and Boards of Trustees.

Both Universities strive to achieve income from all possible resources as do all private medical schools. We raise funds by above average tuition, private gifts and grants and alumni contributions. In addition to this, we receive federal funds.

However, in spite of all these efforts, we need what most private medical and dental schools have, i.e. additional support from State or State-like legislation.

Sincerely,

SEYMOUR ALPERT, M.D.,
 Vice President, *George Washington University*.
 T. BYRON COLLINS, S.J.,
 Special Assistant to the President, *Georgetown University*.

GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE,
 GEORGETOWN UNIVERSITY SCHOOLS OF MEDICINE AND DENTISTRY,
 March 1974.

CONTINUATION OF D.C. MEDICAL AND DENTAL MANPOWER ACT OF 1970 (P.L. 91-650)

(H.R. 11108 by Messrs. Diggs, Nelson, Stuckey, Dellums, Rees, Fauntroy, Howard, Rangel, Breckinridge, Stark, Broyhill of Virginia, Gude, Landgrebe and

McKinney; H.R. 11207 by Messrs. Flood, Kyros, Mann, Carter, Parris, Conte, Shriver and Hastings; H.R. 11186 by Mr. Patten; H.R. 11535 by Messrs. Rogers, Jones of Oklahoma, Roy, Symington, Hansen of Idaho, Preyer, Brown of Michigan and Mrs. Green.)

Purpose of Legislation: To extend the D.C. Medical and Dental Manpower Act for three years in order to provide financial distress funds for the private medical and dental schools in the District of Columbia. The District of Columbia Subcommittee on Labor, Social Services and the International Community has changed the bill to extend for only two years in order to provide sufficient time to seek a more permanent solution to our problem.

Method: By authorizing the Secretary of Health, Education and Welfare to provide funds to the Schools of up to \$5,000 per year for each medical student and up to \$3,000 per year for each dental student in accordance with demonstrated financial need.

History: P.L. 91-650 authorized funds to meet the critical operational deficit of these Schools. Primarily due to the impetus of this law, the Secretary of Health, Education and Welfare, through his discretionary funds, has for three years given grants to keep these Schools open.

Similar Support Given by the 50 States: Only four states (Connecticut, New Hampshire, Nebraska and Missouri) do not provide financial assistance to the private medical schools within their boundaries. Two of these states (Missouri and Nebraska) currently have legislation in process. Eighteen states participate in Regional compacts. The average state support is in excess of \$5,000 per student. Dental school programs are similar. (Please see the attached list for more detail.)

Howard University: Howard University presently receives operational funds from the Department of Health, Education and Welfare. Howard supports our efforts to obtain government funding.

Necessity for These Financial Distress Funds: The School of Medicine at George Washington University and the Schools of Medicine and Dentistry at Georgetown University cannot remain in operation without the funds to be authorized by the continuation of this legislation. There are fourteen area hospitals directly dependent on the staffs and programs of these Medical and Dental Schools. There are almost 11,000 graduates of these schools practicing in all fifty states and the District of Columbia. The present classes of these Schools number over 1,800 students representing 46 states and the District of Columbia.

SEYMOUR ALPERT, M.D.,

Vice President, *George Washington University.*

T. BYRON COLLINS, S.J.,

Special Assistant to the President, *Georgetown University.*

GEOGRAPHIC DISTRIBUTION OF CURRENT STUDENTS (1973-74) ATTENDING THE GEORGETOWN UNIVERSITY SCHOOLS OF MEDICINE OR DENTISTRY AND THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE. ALSO, GRADUATES IN PRACTICE

State	Current students	Graduates in practice	Type of school		State support of private in-State medical or regional medical school
			Public	Private	
Alabama.....	4	45	2	-----	Southern regional, \$3,250 per student.
Alaska.....	0	10	-----	-----	Western regional, \$3,000 per student.
Arizona.....	11	80	1	-----	Do.
Arkansas.....	2	5	-----	-----	Do.
California.....	158	910	5	3	\$12,000 per additional 55 students.
Colorado.....	6	65	1	-----	-----
Connecticut.....	86	508	1	1	-----
Delaware.....	9	44	-----	-----	\$7,500 per student.
District of Columbia.....	108	892	1	2	District of Columbia Medical-Dental Act and HEW funds.
Florida.....	27	376	2	1	\$6,500 to \$8,500; Southern regional, \$3,250 per student.
Georgia.....	3	71	1	1	Southern regional, \$3,250 per student.
Hawaii.....	2	33	1	-----	Western regional, \$3,000 per student.
Idaho.....	2	38	-----	-----	Do.
Illinois.....	18	105	2	5	\$6,000 to \$7,000.
Indiana.....	8	47	1	-----	-----
Iowa.....	0	21	1	-----	-----
Kansas.....	6	18	1	-----	-----
Kentucky.....	2	32	2	-----	Subsidy by negotiation.
Louisiana.....	1	27	2	1	Southern regional, \$3,250 per student.

GEOGRAPHIC DISTRIBUTION OF CURRENT STUDENTS (1973-74) ATTENDING THE GEORGETOWN UNIVERSITY SCHOOLS OF MEDICINE OR DENTISTRY AND THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE. ALSO, GRADUATES IN PRACTICE—Continued

State	Current students	Graduates in practice	Type of school		State support of private in-State medical or regional medical school
			Public	Private	
Maine.....	12	60			New England regional, \$2,500 to \$5,000 per student.
Maryland.....	199	1,234	1	1	Negotiated yearly; Southern regional, \$3,250 per student.
Massachusetts.....	136	637	1	3	New England regional, \$5,000 per student.
Michigan.....	9	106		3	
Minnesota.....	2	44	2		\$8,000 per Minnesota student.
Mississippi.....	1	12	1		Southern regional, \$3,250 per student.
Missouri.....	4	37	2	2	Legislation pending.
Montana.....	4	15			Western regional, \$3,000 per student.
Nebraska.....	0	3	1	1	Legislation pending.
Nevada.....	8	30			Western regional, \$3,000 per student.
New Hampshire.....	14	57		1	
New Jersey.....	188	950	2		
New Mexico.....	4	33	1		
New York.....	423	1,723	4	8	\$3,900 to \$6,000.
North Carolina.....	5	131	1	2	\$3,000 per North Carolina student; Southern regional, \$3,250 per student.
North Dakota.....	5	10	1		
Ohio.....	33	193	2	2	\$5,400 per student (approximately).
Oklahoma.....	3	26	1		
Oregon.....	4	43	1		
Pennsylvania.....	91	641	2	5	\$4,400 to \$7,465.
Rhode Island.....	20	183		1	Special grant; New England regional, \$5,000.
South Carolina.....	3	56	1		
South Dakota.....	5	8	1		
Tennessee.....	5	31	1	2	Negotiated; Southern regional, \$3,250 per student.
Texas.....	8	119	5	1	\$17,282.
Utah.....	40	102	1		
Vermont.....	2	23	1		
Virginia.....	110	729	2	1	Southern regional, \$3,250 per student.
Washington.....	29	109	1		
West Virginia.....	4	39	1		
Wisconsin.....	7	54	1	1	\$4,500 per student (approximately).
Wyoming.....	1	10			Western regional, \$3,000 per student.
Totals.....	1,835	10,775	66	45	

THE GEORGE WASHINGTON UNIVERSITY,
Washington, D.C., March 12, 1974.

Hon. ROMANO L. MAZZOLI,

Chairman, Subcommittee on Labor, Social Services and the International Community, Committee on the District of Columbia, U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN MAZZOLI: I am writing in response to the statement requested by Representative Mazzoli regarding the administration of private medical and dental schools in the District of Columbia, made available during a meeting with the Assistant Secretary for Health on February 21, 1974. It is my understanding this document, with minimal modifications and/or additions, was formally transmitted to you through a covering memo dated February 22, 1974. I presume it was prepared in the office of Dr. John S. Zapp and that it is alleged to represent his response to your request during a meeting on February 7, 1974 of representatives of George Washington and Georgetown Universities and the Department of HEW with the Subcommittee on Labor, Social Services and the International Community of the Committee on the District of Columbia regarding H.R. 11108.

In my opinion, the statement referred to above does not respond to your request for documentation of deficiencies in management and administration.

Reference is made in this latest document to "intensive review" of the application during the last three years under the financial distress program "by expert consultants drawn almost exclusively from experienced Medical Center administrators and financial management personnel of such institutions." It is also stated that virtually all outside consultants voiced criticism about various aspects of our operation and uncertainty because of confusion in the data supplied which was not consistent and understandable.

It is further stated that the AAMC Cost Study generated data which "appeared inconsistent with the financial statement submitted by the school".

I repeat my testimony before your Subcommittee, and confirmed by the statement of Dr. Harry Bruce, that prior to February 27, 1974 George Washington University was never site visited under the Distress legislation; furthermore, George Washington University was not a participant in the AAMC Cost Study referred to and therefore the inconsistency referred to above could not have existed. If there are remaining "areas requiring clarification", we have not been so informed.

It should be pointed out that the statement specifically addresses only "the current round of application review" and that it was prepared prior to the very recent site visit of February 27, 1974 to which I shall refer later in this presentation. The "excerpts from reviewers" could only represent present and past HEW staff and not the opinion of any outside "experts or consultants".

Funding during the three-year period of the Distress legislation has been \$4,706,459 and not \$5,290,600 as stated on page seven of the document, and this year's requirement will be approximately \$2 million and not \$2,782,210.

The second reviewer refers to increasing deficits each year and to "huge expense increases" and "inability to curtail total expenditures". In fact, when one removes the unavoidable increased plant cost associated with the move to the new Medical School and Library, as can be seen from Attachment 1, deficits decrease substantially. This irrefutably demonstrates that costs of the Medical School have been brought under control relative to the School's income base, except for the substantial unavoidable increases in operation and maintenance of plant.

There are basically two causes for the increase in plant cost. The first is the tremendous upgrading of Medical School and Library facilities which was imperative in view of the woefully inadequate 100-year-old buildings previously occupied. The old structures were not air-conditioned; were inadequately wired for modern scientific equipment; were heated by an antiquated coal boiler system; and were located a mile from Clinical Center activities. The second cause for the substantial increase in plant cost relates to the unanticipated, skyrocketing price of fuel oil and other utilities.

The statement submitted by HEW compares percentage increases and expense from the 1972-73 actual to the 1973-74 budget. As already indicated, we anticipate budget underruns, as has been the case in the past, underruns caused in no small part by aggressive cost containment efforts.

We are accused of not having "followed the common practice in other medical schools of instituting a viable intramural faculty practice plan". In fact, The George Washington University intramural Practice Plan is now five years old, and it is one of the most sophisticated among the 115 existing medical schools. There is total participation by the full-time clinical faculty and total University control—without exception. The income from this Plan supports 50% of all clinical faculty costs, after which the surplus, generated almost entirely by the so-called hospital-based departments of Anesthesiology, Pathology and Radiology, is used to neutralize University Hospital deficits. It is only appropriate that patient-care activity income be used for this purpose, since the Hospital is carrying 35% (\$4 million in FY73) of clinical faculty costs. If it were not, an unmanageable Hospital deficit would be created which would have to be charged back to the educational programs of the School of Medicine. The net effect would be no different.

It has been stated that the "precise disposition of the fund balances derived from the professional practice plan is difficult to determine" and "a substantial reserve exists which is operating as an endowment." In fact, the precise disposition of these funds is fully and clearly disclosed in the Distress Grant applications and appendices thereto, including the annual University Financial Statement. The funds are functioning as an operating reserve and not as an endowment.

Even with the full utilization of all reserve funds, the cash position of the Medical Center Fund Balance Sheet on 6/30/73 showed a \$1.5 million negative balance. Without these appropriated and unappropriated funds the Medical Center, with a \$45 million budget and substantial accounts receivable from patient care activities, would have virtually no working capital. Furthermore, it is these funds which provide the fiscal assurance necessary to budget for a succeeding year.

The statement refers to actions taken by other medical schools, and implies that similar actions have not been taken by The George Washington University School of Medicine and Health Sciences. It refers specifically

to "shifting costs to Hospital budgets where appropriate". As already indicated, in FY73 The George Washington University Hospital carried \$4 million of educational costs and this level of support is projected into the future. Since 1966, costs have been shifted from the Medical School to the Hospital to the maximum extent allowable by third party reimbursers.

Finally, as a result of your suggestion during the recent hearings, we were site-visited for a full day on February 27, 1974. The site visit team was composed of high-ranking individuals in four major medical centers. Our records were examined and we were interviewed exhaustively. The results of this review have not been made available to us, however, the report of these consultants may shed light on the true nature of our distress.

In conclusion, reference is made to the recently released Institutional Profile Banking Report of the Association of American Medical Colleges which provides data for FY72 on sixteen selected school characteristics for all 92 medical schools fully operational at that time. As you can see in Attachment 2, The George Washington University School of Medicine & Health Sciences ranked as follows:

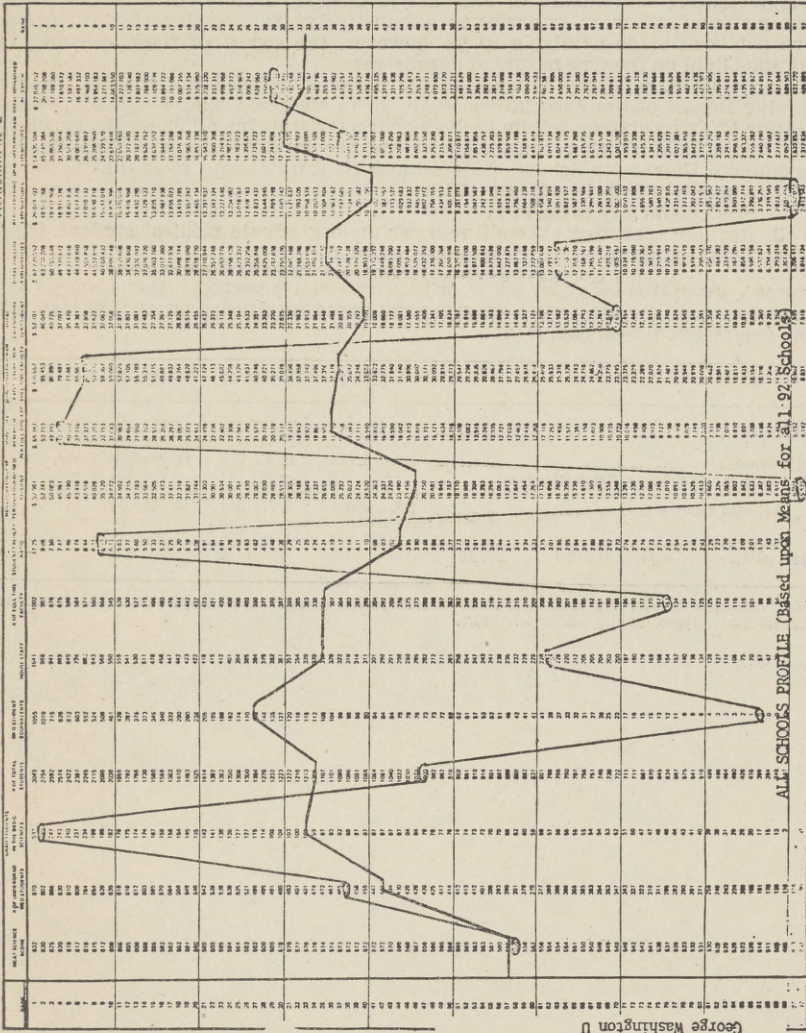
1. Number of full-time faculty, 76th
2. Student-faculty ratio, 9th
3. Regular operating expenditures per undergraduate medical student, 92nd
4. Total regular operating expenditures, 91st

THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE & HEALTH SCIENCES OPERATING INCOME AND EXPENSE RESTATED FOR FISCAL YEARS 1970-71 THROUGH 1973-74 BY EXCLUDING THE COSTS OF OPERATING AND MAINTAINING THE PHYSICAL PLANT

	1970-71	1971-72	1972-73	1973-74
Total income.....	\$6,921,303	\$7,610,371	¹ \$9,997,603	\$10,843,000
Total expense.....	9,076,762	9,397,633	11,066,150	12,843,000
Deduct costs of operating and maintaining plant.....	-501,770	-626,534	-711,204	-1,712,048
Adjusted expense.....	8,574,992	8,771,099	10,354,946	11,130,952
Adjusted deficit.....	-1,653,689	-1,160,728	-357,343	-287,952
Percent deficit to total expense restated.....	19.3	13.2	3.5	2.6

¹ Total recorded income for 1972-73 was \$10,281,217, of which \$283,614 was an extraordinary item related to the recover of indirect costs on sponsored programs for prior years.

Attachment 2



Legend: All Schools

GEORGETOWN UNIVERSITY MEDICAL CENTER,
Washington, D.C., March 12, 1974.

HON. ROMANO L. MAZZOLI,
HON. GILBERT GUDE,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. MAZZOLI AND MR. GUDE: I am pleased to have the opportunity to respond to the statement submitted by the Assistant Secretary of HEW concerning the management of the Georgetown University Schools of Medicine and Dentistry.

I trust that the attached general response (Phase I) and then detailed item by item response (Phase II) will be of assistance to you. This information represents our response to the specific charges as identified in testimony offered before the Subcommittee on Labor, Social Services and the International Community by John S. Zapp, D.D.S., Deputy Assistant Secretary for Legislation (Health).

If I may supply additional information or detail, please just have your office let me know.

Cordially,

MATTHEW F. McNULTY, Jr., Sc. D.,
Executive Vice President
for Medical Center Affairs.

Attachment: Phase I Report, Phase II Report.

GEORGETOWN UNIVERSITY, GEORGETOWN UNIVERSITY MEDICAL CENTER

Response to undated statement submitted by staff, Department of Health, Education and Welfare to the Honorable Romano L. Mazzoli, Chairman, the Subcommittee on Labor, Social Services and the International Community of the Committee on the District of Columbia. Statement was to elaborate on the original testimony of John S. Zapp, D.D.S., Deputy Assistant Secretary for Legislation (Health) before the subcommittee on Thursday, January 24, 1974.

Georgetown University and its Medical Center appreciate the opportunity of this response to the observations made in the cited testimony and in the supplemental report.

This reply will be in two parts. First and directly hereafter as Part I will be outlined briefly a general response to indicate broadly not only the incorrectness of the accusations, but to submit general information concerning the effectiveness of the programs in medicine and dentistry at Georgetown University.

Secondly, the charges from DHEW warrant full response. However, several of the observations by DHEW relate to complex program activities. The information submitted in reply, therefore, is necessarily lengthy in detail. Such detailed responses may or may not be of interest to all who review this material. Thus, we have chosen the method of providing full documentation in Part II for those who wish to view the material in that detail.

We believe it is important to emphasize that the items outlined by the Deputy Assistant Secretary for Legislation (Health), in both his testimony of January 24, and the supplemental statement have never been previously communicated to Georgetown University.

Beginning in 1970, representatives of the Office of the Secretary, DHEW, twice previously testified on this subject. One such testimony was by the then Director of the National Institutes of Health. The other was by the then Assistant Secretary for Health and Scientific Affairs, DHEW. At no time were items of "deficient administration" cited to Georgetown University.

In February, 1973, the FY 1973 applications for "Distress Awards" for both Georgetown University and George Washington University were denied by action of the National Advisory Council. The Council later reversed its decision and FY 1973 awards were made to both institutions. The point of this information, however, is to indicate that in initially denying applications, the formal communication made no reference to "deficiency in administration."

The official communication indicated that the National Advisory Council "... appeared sympathetic to the unique circumstances surrounding D.C. schools and recognized the absence of state support." The communication also indicated the dilemma with which Georgetown University has struggled in recent years.

On the one hand, contributing economy of scale, our Schools of Medicine and Dentistry at Georgetown have enlarged enrollment significantly to produce more physicians and dentists for Washington, D.C., the area and the nation. On the

other hand, the University is criticized for taking an action which certainly seemed in the public interest.

Since 1969 the enrollment in the School of Medicine has been enlarged from 464 to 820 in the academic year starting this September. The graduating class has increased from 112 in 1969 to 165 in 1974. Starting in May, 1975, and thereafter there will be approximately 200 graduates annually in the medical program.

This same principle of economy of scale and enlarged contribution of dental practitioners is being accomplished by our School of Dentistry.

Georgetown University has exercised every effort at public hearings before the Committee on the District of Columbia of the House of Representatives, and elsewhere, to disclose for review by supportive and opposition interests the details of operation of the Georgetown University Medical Center. Our intent has been to communicate through full public disclosure to the Congress, to the Department of HEW and to society at large, the problems and needs of the Georgetown University Schools of Medicine and Dentistry.

We have practiced "full and detailed public disclosure" as a method of evidencing a need with confidence in the objective, constructive judgment of the Congress and the citizens of this country.

Despite these methods of full public disclosure to identify the problems and needs, the issues recently have been continuously diverted by intransigent, single-minded opposition by key HEW officials.

Not all officials of HEW have opposed state-like assistance to Georgetown University and George Washington University. The record demonstrates that HEW officials have documented their support of state-like assistance for private medical and dental education, including Georgetown and George Washington Universities. With some officials there has existed a difference of opinion as to method of funding, but with strong support as to fundamental need of support.

An example of what we term "single-minded opposition" is contained in the cited testimony by the Deputy Assistant Secretary for Legislation (Health). That testimony indicates, "the Department has the view that . . . the financial uncertainty experienced by these schools . . . reflects a serious deficiency in the administration of these institutions." This fallacious and unrestrained broadside is damaging to the institution and to the officials in whom the management responsibility is placed.

The Executive Vice President for Medical Center Affairs and the Deans of the Schools of Medicine and Dentistry at Georgetown University combined represent almost 100 years of experience of clearly identifiable success in managing health science and health service programs of national significance and magnitude, both at Georgetown and at other institutions.

The graduates of these two Georgetown schools, the public they now serve and the public to be served in the future by these and other practitioner, research and educational graduates in every state, the District of Columbia, and abroad demonstrate the injustice of such undocumented a charge as ". . . seriously deficit in administration." The end products of Georgetown University Schools of Medicine and Dentistry through excellence of education have been eminently successful in contributing to the health of the nation as capable practitioners, research scientists and educators.

For some Department of Health, Education and Welfare officials to adopt an attitude in the last paragraph of the supplemental statement that indicates ". . . some private schools without state aid and limited reserves or with markedly restricted assistance . . . have made a 'go of it' during these days of rising cost and fluctuating federal support" would appear to be an attempt to establish a standard which could be dangerous public policy for the health of the people of this country.

On the other hand, even this last cited negative position does identify that the most deprived of private schools receive "markedly restricted assistance." The broader implication is that private schools are not deserving resources assistance unless they are "bankrupt."

This phenomenon of "going bankrupt", or submission of proof of abject poverty in the higher education sector of our country is well-known. Despite the capable efforts of many talented educational administrators, it does occur. An example of the dilemma is the plight of Columbia University—one of the earliest institutions of higher education in our country. Despite the great strengths of that University, they are not able to finance their College of Pharmacy. That program has lost its accreditation. It is apparent that Columbia University has no course of action but to discontinue its pharmacy education opportunity. Exhibit I

attached to this section of our report outlines the dilemma. It is hoped that DHEW does not level at Columbia University the charge "... seriously deficit in its administration."

One other general observation which we suggest is typical of the back-up document furnished by the Office of the Secretary, DHEW. The supplemental document indicates "very little commitment to improve their present practice plan." This statement implies that the opportunity for institutional benefit from private practice income of the medical and dental faculty is a simple matter easily administered with potential for tremendous revenue.

In 1965 upon instruction by the Board of Directors, Georgetown University initiated a medical faculty practice plan. That institutionally rewarding faculty practice plan has been ongoing since 1965. For the 1974 fiscal year that plan will benefit the School of Medicine by more than \$2,000,000 of income. The Georgetown University School of Dentistry Clinic will benefit that school by more than \$1,000,000 of income. Yet HEW charges "very little commitment." Further, DHEW discloses no dimensions of the problems on this subject faced by schools of medicine (and schools of dentistry) countrywide. Some interpretations of these problems can be gleaned from a brief review of the attached Exhibit II.

The issue of University medical and dental professional faculty practice plan operation is not a "right or wrong" subject. This issue has been administered vigorously and carefully by Georgetown University. However, this matter is by no means simplistic; as the attached article indicates, the dollar benefit to be gained while significant is not a "solve all" method of financing medical education. Georgetown University is now obtaining a significant dollar benefit from this source. Through further refinements constantly in progress, more significant benefit will be obtained in the future. However, as all medical educators agree, a faculty practice plan will not support a school of medicine or dentistry.

Passage of H.R. 11108 is essential to the successful operation of the Schools of Medicine and Dentistry at Georgetown University. Every effort at economy of operation and promotion of additional income from all sources has been exercised. For some representatives of the Department of Health, Education and Welfare to then demand further that two notable institutions in the nation's capital, standing in some measure as examples of health science education to the free world, must prove that they will "go broke", or, close their health science education doors, or, lose accreditation before some officials of DHEW will support before the Congress an appeal for a state-like financial support similar to that already received from the Congress by Howard University Medical Center and from state legislatures by a clear majority of other private university schools, does seem an unusual public policy position.

Thank you for this opportunity of response in general to the January 24, February 7, and subsequent statement by the Deputy Assistant Secretary for Legislation (Health). Response item by item to the allegations in the DHEW statement follows in the order cited in the statement.

Attachments: 1. The Chronicle of Higher Education, February 11, 1974. 2. Hospital Tribune, Monday, February 25, 1974, March 1974.

EXHIBIT I

[From the Chronicle of Higher Education, Feb. 11, 1974]

COLUMBIA'S PHARMACY COLLEGE LOSES ITS ACCREDITATION

The financially troubled Columbia University college of pharmaceutical sciences has lost accreditation, but hopes to get it back long enough for present students to graduate.

Stephen M. Gross, acting dean, said last week that the college has asked the American Council on Pharmaceutical Education to extend accreditation two years. Without such an extension, he said, the college would have to close at the end of the spring semester.

EXHIBIT II

[Hospital Tribune, Feb. 25, 1974]

PRIVATE PRACTICE INCOME IS PROBLEM FOR MEDICAL FACULTY

New York—How much money state medical faculty members should keep from private practice income has become a matter of sharp debate since New York State comptroller Arthur Levitt charged last month that many practicing pro-

fessors have been regularly cheating the state of its share—anything exceeding 50 per cent of the teacher's base salary.

The limit was stretched, Mr. Levitt claimed, by questionable expenses added to make net incomes fall within the allowable range. The true fault, he said, lies with the state university system and the medical centers themselves, which made practically no efforts to enforce controls.

SALARY RAISES SUGGESTED

In the absence of self-regulation, the comptroller recommended raising salaries to true full-time levels, so faculty would not have to rely on outside income, and depositing all outside funds in a central pool for use by the medical center under strict state budgetary controls. With this scheme, he reasoned, it would no longer be possible for the big money-earning departments to build up large surpluses and spend money without budget justification and expenditure guidelines.

Reaction to the report was diverse. Dr. Calvin H. Plimpton, president and dean of Downstate Medical Center—which came under heaviest attack in the audit—supported Mr. Levitt's approach. "It would make everyone's life easier," he commented. "It's a way of getting top people into medical schools."

But among Downstate faculty members, the plan is considerably less popular. In fact, a number even oppose a recently negotiated contract to raise the limit on private practice to 75 per cent of their shares on the grounds that it is grossly unfair to those who earn significant sums of money.

"If a man makes \$20,000 and brings in \$100,000 in outside income," said a faculty member who asked not to be identified, "he only gets to keep \$15,000." Moreover, a faculty group has filed a suit to contest the state's right to claim private practice income at all—perhaps the motivating factor behind Mr. Levitt's attack on Downstate, one faculty member suggested.

LACK OF INCENTIVES CRITICIZED

Aside from considerations of fairness, the full-time plan incurs criticism around the country for its lack of incentives. "I have a personal bias," said Bernard Siegel, vice-president for business and finance at Albany Medical College, "against putting people on a state salary and then expecting them to do all this stuff that's going to generate income. That's a disincentive. The doctors don't want to see patients, so it doesn't meet patient care needs and it doesn't result in the amount of income that should be coming back to the university."

In fact, a number of schools that have experimented with the full-time plan have become disenchanted. At the University of Illinois, vice-chancellor for health services Dr. Harold Engle described the system as "primitive" because each faculty member gets a contract for a year and "nothing he does within the year changes that."

At the University of Missouri, the full-time plan is about to be modified because, according to director of the medical center Dr. William D. Mayer, "although there are some incentives, those incentives only become apparent on an annual basis on negotiation of salary. The incentive is pretty far removed. We're in the process of trying to figure out how to build more pertinent, individualized incentives." The probable solution is a base salary contract plus an individualized account, with an established percentage of the person's outside earnings.

Dr. Mayer does not feel it is fair for specialties to share funds equally. "We've functioned under the assumption that the market place does in fact have something to say about salary levels. Surgeons make slightly more than radiologists, who make slightly more than pediatricians. If you believe in that as an acceptable philosophical base, then the market place itself in terms of income has to deal with those issues."

"ONLY WAY" TO HAVE CONTROL

Dr. Leon O. Jacobson, dean of the University of Chicago—a private institution—thinks the full-time system has its good points. "It's the only way you can have control," he said. "Otherwise, in an academic setting, you don't even know what your people are making." But again the school is looking for ways to inject incentive. Dr. Jacobson feels it depends on how much responsibility you put in the departments. Let's say I'm in the department of medicine and I see 10 patients two afternoons a week. If I saw 15, the money from the

extra five could be used for the department itself so there's an incentive to do more."

At the University of California at San Francisco, business officer Richard Littlejohn thinks Comptroller Levitt's approach is partially correct. "I do think that's a step in the right direction," he commented, "because no one has a personal responsibility for generating the money. But on the other hand, letting people earn part of their own salary is a very direct incentive. Where there's a pool, physicians tend to back away from the disadvantages of private practice."

At the University of California at San Francisco—which is not representative of the whole University of California system since each school has its own plan—faculty practice is regulated by a ceiling, with a maximum earning of one and one-half times the base salary (\$50,000 on a \$20,000 salary, for instance), the actual amount negotiated with the department chairman and the dean. Although there are controls to ensure that professors will not devote an excess of time to private practice—limits on numbers of patients in hospital and office hours limited to two and one-half days a week—Mr. Littlejohn admits that the system is abused.

PLAN BASED ON SLIDING SCALE

There is no specific plan at the University of Southern California, but Dr. George Jacobson, chairman of the Radiology Department, is heading a faculty committee to evolve a plan that will probably be based on a sliding scale. "Otherwise," he says, "surgeons could generate enough funds in a month and then wouldn't do anything for six months. That's self-defeating. With a sliding scale, you can keep 75 per cent up to x amount. On the next \$5,000 you generate, you can keep 60 per cent. Like income tax, the more you earn, the less you get to keep, but you can always earn more." The plan has not as yet been accepted by the university.

GEORGETOWN UNIVERSITY

GEORGETOWN UNIVERSITY MEDICAL CENTER

RESPONSE TO STATEMENTS SPECIFICALLY REFERRING TO GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

"These institutions have applied for financial assistance because of need each year since 1968." (Page 2, Paragraph 5.)

We believe this statement to be false, however, not being privileged to the discussion resulting in this statement, it could be construed that such programs as the Special Project Grants or the Basic Improvement Grants received since 1968, may have been considered as grants to the school on the basis of "need." We feel, however, that since these grants undertook specific projects which indirectly created a need that they should not have been considered in the same manner as funds received from distress legislation. We would concur that since FY 1971, we have received distress funding. This is demonstrated in Exhibit 4, which outlines the amount actually received in FY 1971, 1972, and 1973, and the amount requested in FY 1974. This involved not only the expansion of the physical facilities to meet the expanded student body, but also to successfully meet the incorporation of new programs which were accompanied by expanded technological needs. Much of this expansion was accomplished because of the successful identification of outside funding for specific areas.

"The outside expert consultants have usually recommended disapproval or expressed uncertainty because of confusion in the data supplied." (Page 3, Paragraph 1)

We are uncertain as to the confusion which is alluded to in the foregoing statement. We have attempted since the first submission of our distress application in FY 1971, to report data as requested in these applications. As I am sure each of you are aware, it is highly unlikely that any two institutions of the magnitude and complexities of health science centers like Georgetown University would have fiscal operations exactly alike. Since the submission of our first application, and I believe the Department concedes to this, Georgetown University has made significant strides in refining data collection processes and has implemented significant changes in data collection areas such as indirect cost accounting.

"Continuance of the apparently arbitrary 60-40 percent allocations of costs in the basic science departments to the medical and dental schools" (#1—Page 4, Paragraph 5)

The above claim by the consultants and staff reviewers is thoroughly unjustified. As I am sure you are aware, the services and facilities of the basic science departments are used almost exclusively by the freshman and sophomore classes of the Schools of Medicine and Dentistry. With respect to this fact, the costs of the six basic science departments are allocated to both schools on the basis of the number of students enrolled in the freshman and sophomore classes.

Although it is not clear exactly which year's distress application the above comment is directed to, it is apparent from Exhibit 5 that in fiscal years 1971 to 1974, the ratio of freshman and sophomore students in the School of Medicine to those in the School of Dentistry does indeed justify the 60:40 percent allocation of costs.

Lack of information regarding the schools' clinical practice plan. (#2, Page 5, Paragraph 1)

On May 8, 1973, I submitted additional information as an addendum to Georgetown University's Application to Participate in the Program of Grants to Assistant Health Professions Schools Which Are in Financial Distress to Peter L. Eichman, M.D. (former Deputy Director, Bureau of Health Manpower Education). This addendum provided the following information with respect to the School of Medicine's Clinical Practice Plan:

Attached is a revised exhibit which we trust indicates precisely the income contributing to the operation of the School of Medicine from faculty practice and other miscellaneous faculty income benefits (the combination of which is locally tilted, "Faculty Service Income"). This schedule arrays on one presentation the faculty practice earnings previously demonstrated in different locations in our original application.

All funds shown on the attached schedule are controlled and credited as direct revenue to the School of Medicine. Budgets for the expenditure of these funds are prepared as an integral part of the regular budget process followed by all schools of the Medical Center. These budgets are reviewed and approved by the President, a Committee of the Board and finally by the full Board of Directors of the University. Faculty practice income is used for and supports the direct expenses of operating the Medical School. The use of these funds can be demonstrated on a cost center by cost center basis.

We agree that our previous method of identifying faculty income under different funds as developed by local traditional practice did not make possible the clear identification of a significant and growing contribution to the operation of the School of Medicine.

The totals shown on the attached exhibit do not change the gross revenue total for 1972-73 shown on Page 4 of the original application. The revised schedule is a regrouping of faculty practice revenue previously presented in several different categories and thus not a very clear presentation. Of the total shown on the attached schedule, \$1,538,319 was previously shown as Medical School Sponsored Program revenue; \$491,496 as Medical School Hospital Service revenue (faculty practice revenue from an absolute full-time Hospital based specialties—all "Hospital based" specialists are absolute full time on University salary with all earnings deposited to controlled University funds for support of the School of Medicine) and \$100,000 as Medical School—Other Revenue Miscellaneous Earnings.

It is planned that the amount of faculty practice income will continue to grow as one of the methods of financing the Schools of Medicine and Dentistry. This is the plan of the University and its Medical Center.

For the past three years every new full-time clinical faculty member under sponsored program support (new positions against University funds have not been permitted for the last several years) has been recruited with the requirement of membership in the Faculty Practice Plan. This practice of absolute (for Hospital based clinicians) or fully controlled faculty appointment policy will continue. In addition, even the few remaining "grandfather" exemptions are voluntarily joining the Faculty Practice Program. Negotiations are currently underway and are expected to be completed by July 1, 1973, to convert these additional geographic full-time faculty members to absolute full time. There will then remain only a few long-tenured clinical faculty operating under the "grandfather" provision. These latter faculty are "low earners" but have strong convictions as to "the principal." They will be retiring in a few years. Their practice income is limited by age, personal activity, type of discipline and by allocation of time.

*Georgetown University Medical Center faculty service¹ revenue, 1972-73
estimated (confidential)*

Department:	<i>Faculty service plans revenue to school</i>
Pathology -----	\$86,310
Anesthesiology -----	395,456
Neurology -----	63,332
OB/Gyn -----	53,979
Pediatrics -----	18,730
Physical medicine -----	51,547
Psychiatry -----	100,576
Radiology -----	278,892
Medical director -----	48,532
Medicine, general -----	484,795
Cardiology -----	89,723
Clinical labs -----	100,644
Surgery, general -----	199,136
Neurosurgery -----	15,742
Oncology -----	4,663
Ophthalmology -----	81,601
Orthopedics -----	61,148
Urology -----	6,509
Total -----	2,141,315

¹ A majority of this revenue is generated from faculty practice. However, a small amount comes from faculty providing miscellaneous services for which they are reimbursed and the funds accrue to the school. Thus, at Georgetown these funds are called faculty service plans.

The distress application for the School of Medicine, submitted to Steven J. Garza, D.D.S. (DHEW Region III) on November 15, 1973 included the following information, which appears on page 49-55, pertaining to the School of Medicine's "Clinical Practice Plan":

Until approximately ten years ago, the clinical departments of Georgetown University School of Medicine operated largely under a geographic full-time system with regard to the conduct of clinical practice. The current administration of the Medical Center and the School of Medicine recognizes that an accountable faculty practice program is necessary for the proper management of the affairs of the School. Such a program was initiated several years ago and is now well under way. Under our plan faculty contracts are subject to periodic review by the Dean, Chairman of the Department, and the faculty member concerned. All new faculty members entering all divisions in the Clinical Departments are now recruited on a strict full-time basis. The same has been true of those entering the Basic Science Departments over a long period of time.

Frequent re-examination of the question of faculty practice programs reaffirms that it will not be necessary to move the entire full-time clinical faculty to a strict full-time basis. For good and useful purposes, there is a place in our programs for controlled, geographic full-time members of the clinical departments in certain situations. However, as indicated, with the past decade there has been a substantial reduction in the number of geographic full-time faculty members. On October 1, 1973 of the 312 paid members of the faculty of Georgetown University School of Medicine 41 were part-time, 232 strict full-time, and 39 (16.8% of the paid full-time faculty) were still geographic full-time. Efforts to persuade them to become strict full-time faculty are being and will be continued.

Definitions of strict full-time and geographic full-time are as follows:

Strict full-time faculty members are those who receive their entire professional income in the form of salary and devote their full-time to medical school activities. They may render care to referred patients at the University, or in affiliated institutions but they do not retain fees collected for these services. (Strict full-time faculty members may retain certain industrial or government honoraria, royalties, etc. by agreement with department chairman and dean).

Geographic full-time faculty members are those who receive a portion of their professional income in the form of salary, and a portion in the form of fees paid for patient services, and who devote their full-time to medical school activities.

All practice in the full-time faculty is confined to referred patients seen in their offices on the University campus and affiliated hospitals. In the case of

geographic full-time members, time spent in this activity is regulated by the department chairman and is ordinarily restricted to the equivalent of two half-days per week. Geographic full-time faculty may retain fees unless an individual's fees are voluntarily distributed to the school and department. A summary tabulation of policies concerning sources of personal income for Georgetown University faculty is shown on the next page.

Features of faculty practice arrangements at Georgetown are as follows: 1) All department chairmen are strict full-time. 2) The "hospital based departments" (Anesthesiology, Pathology, Radiology, and Physical Medicine and Rehabilitation) are comprised entirely of strict full-time faculty only. 3) The arrangements in other clinical departments vary, some being entirely strict and others mixed. For example, in the Departments of Medicine and Surgery, a variety of private practice arrangements prevailed for twenty-five years. These departments are being converted on a divisional basis. For example, the Division of Orthopedic Surgery is strict full-time. The Divisions of Cardiology and Pulmonary Diseases in the Department of Medicine are strict full-time divisions. Contractual arrangements with these faculty members vary, but the fees derived as private practice income are deposited with Georgetown University. 4) All new faculty members entering all divisions of clinical departments are currently recruited on a strict full-time basis. A sample faculty contract is shown on the next page. 5) The full-time faculty of the School of Medicine in the Veterans Administration are not permitted to supplement their V.A. salaries with private practice income. Their supplementations are from University payroll. Of the full-time faculty members of the School of Medicine at D.C. General Hospital, one is currently permitted to supplement his income with fees from private practice conducted in specified hours at Georgetown University Hospital. (Supplementations of V.A. and D.C. General salaries are carefully supervised in line with the regulations of these agencies.) Billing and collecting for strict full-time faculty members who are under contract are accomplished by the department or division involved. The distribution of total professional fee income is shown on the following table. The funds derived from private practice when made available to the department or division, may be used and have been used for faculty salaries, non-academic personnel salaries, supplies and equipment for teaching and research, and travel of an approved nature for house staff and faculty. Total expenses are not related to clinical practice plan income.

POLICIES CONCERNING SOURCES OF PERSONAL INCOME—GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

	Strict full time	Geographic full time	Part time paid	Volunteer part time	Full time unpaid
University salary	Entire	Partly pro rata	Pro rata share	None	None, or supplemental.
Fee for patient care service at university.	None	By approved individual or divisional arrangement.	On his own time.	No restrictions	By approved individual arrangement.
Fee for patient care service off campus.	do	None	do	do	With approval of primary employer.
Nonuniversity source of professional income.	With permission	With permission	Unlimited	Entirely	Major source.
Permission to be paid "other earnings" from university sources.	Occasional, by individual arrangement.	Occasional, by individual arrangement.	Yes	No restrictions	Only with permission of primary employer.
May accept consultant fee from university grant/contract.	No	No	Yes, in his private capacity; it is preferable to increase pro rata share.	do	Do.
May bill a university grant or contract or services rendered.	Only if fees are deposited to the credit of the university and do not supplement income.	Only if fees are deposited to the credit of the university and do not supplement income.	Yes, but not in his part-time faculty capacity	No	No.

GEORGETOWN UNIVERSITY MEDICAL CENTER
GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE
FACULTY PRACTICE AGREEMENT

1. This agreement is effective from _____, through _____. It will remain in effect after _____, or until such time as either party notifies the other in writing of his intention to change or terminate the agreement.
2. _____ will be appointed _____ Division of _____, Department of _____ Georgetown University School of Medicine, on a strict full-time basis.
3. _____ salary will be _____ per annum.
4. _____ agrees to care for referred private patients at Georgetown University Hospital and institutions affiliated with Georgetown University School of Medicine. Dr. _____'s personal share of all fees derived from his practice will be turned in to Georgetown University. The income will be deposited in the general operating funds of Georgetown University and credited to the School of Medicine, Department of _____, Division of _____. The income so derived will be used for the following purposes:
 - (a) The first _____ received will be retained by the University and used to defray the cost of operating the _____ Division;
 - (b) Amounts received in excess of _____ will be retained as disburse percent (75%) of such funds will be used to enhance the Division of _____, Department of _____, at the discretion of the Chairman of the Division, and twenty-five percent (25%) will be used to enhance the overall School of Medicine at the discretion of the Dean.
5. Funds derived from the care of patients outside the private referral system are to be distributed to the Department, Division and School in accordance with the current provision of the approved Faculty Practice Plan.
6. The financial affairs of the Division of _____ are to be reviewed on an annual basis with the Chairman of the Department, the Dean of the School of Medicine and the Office of the Vice President for Medical Center Affairs, at the time the budgets of the Center, the School and the Department are reviewed.
7. _____, otherwise, is entitled to all rights and benefits of a full-time _____ with/without tenure in accordance with all published University documents, including malpractice insurance up to the limit then in force and as defined in the contract between the University and the insurer.

_____ (Date) _____
"No indication of consideration of actions to reduce costs when necessary through reduction or elimination of program or activities and other actions to contain or reduce costs": (#3, Page 5 Paragraph 1)

Georgetown University Schools of Medicine and Dentistry find themselves in a unique position in that the principal for distress funding is the obligation for schools to achieve an economy of the magnitude that would remove them from a deficit operation position. At the same time it has been Georgetown's commitment to significantly expand student enrollments in both schools to meet . . . "the critical shortage in health manpower professionals that exist in the United States." The two philosophies are somewhat contradictory.

As we have indicated before, it was not our intent to seek financial assistance from distress funding, rather to establish a mechanism of state-like support for our Schools of Medicine and Dentistry. It was after the enactment of this public law and on the advice of the Secretary of DHEW, that we did not seek an appropriation under this law but rather sought the needed funding from the distress legislation. Subsequently and again on the advice of the Secretary we agreed to let the legislation contained in PL 91-650 expire.

As you are very much aware, it is now our purpose to secure the successful reenactment of this public law in view of the changing philosophy of the DHEW and the eventual expiration of the distress funding mechanism.

Because we had not sought distress funding, it was not our intent that we should move forcefully toward such drastic measures as the closing of one or both of our schools or a drastic reduction in the number of faculty. Rather, it was our aim to meet our obligation of educating significantly expanded classes in both schools while at the same time realizing economies of scale and

maintaining excellence in education. We believe that we have now successfully accomplished both of these aims. (For example, the deficit per student was reduced from \$3,593 in Fiscal Year 1971 to \$2,232 in Fiscal Year 1973.)

Specifically with regard to the charge as stated in the beginning of this section, I would call your attention to Exhibit b, an attachment which we prepared sometime ago and submitted to Dr. Eichman, M.D.), former Deputy Director, Bureau of Health Manpower Education, during his review of our grant application for FY 1973. I think that you will agree that for a time when we have been dedicated to expanded student enrollments, we have done so as economically as possible under conditions and demands that would have normally warranted significantly greater increases in both faculty numbers and related costs.

Continued program expansion in some cases substantial. (#4, Page 5, Paragraph 1.)

The response to this charge is again directly related to our dedication to the expansion of the student bodies. As you are aware, the first two years of the curriculum of both the Schools of Medicine and Dentistry are largely taught in the basic science areas. In order for the preclinical science areas to assume an almost doubled enrollment of medical students and a significant increase in the number of dental students, a significant program expansion had to be accomplished. I would note that this expansion was accomplished at a time when the student:faculty ratio for these departments increased some 36.8% from 7.6 to 10.4 students per faculty member. We believe that this increased student:faculty ratio demonstrates the realization of a true economy of scale.

"Continuance by the school of the contentions that in the absence of federal support the University Board of Directors will have to consider relinquishing control of the school with no satisfactory explanation of what this means" (#5, Page 5, Paragraph 1)

As I am sure you understand, the possibility and probability of the Georgetown University Schools of Medicine and Dentistry closing because of financial deficits is difficult to assess. The governance authority of a university must make that awesome decision to close a school. The possibility or probability of an action such as this can best be assessed by a review of the record.

In 1968, the Board of Directors of Georgetown University directed University and Medical Center operating officials to explore all possibilities for a solution to the financial deficit of the Medical Center. The Board indicated that the University could not continue to support such deficits which at best would mean a stifling of the scientific and technological development in the Medical Center and concurrently lead to the decay of the educational process of the other University schools.

In pursuing the directives of the Board of Directors alternatives suggested were separate incorporation and the transfer of responsibilities for the Medical Center to other public or private agencies. A third alternative which was explored and deemed most feasible was an enactment of a public law which would establish for the School of Medicine and Dentistry a mechanism of state-like support. Again as you are aware, the successful enactment of PL 91-650 made this alternative a reality. The University Board of Directors assessing that this public law would, in fact, provide the mechanism to offset deficits felt that its charge to administrative officials had been accomplished.

With the expiration of PL 91-650 and the eventual expiration of distress funding, the University Board of Directors is again faced with the potential of significant deficits in future years. I believe that they will again direct that the alternatives of separate incorporation or transfer of responsibilities and liabilities for these schools to other public or private agencies become a mandate.

I believe that it is fair to assess that while each of these alternatives received a significant review in 1968 and 1969, there is likely to begin an even more in-depth study of these alternatives if there is not reenactment of PL 91-650.

"Treatment of unapplied gifts as assets rather than income" (#6, Page 5, Paragraph 1.)

With the establishment of a new fund raising program (Mandate 81), the following policy was adopted as of July 1, 1971. In the case of all unrestricted gifts received by the University, no amount was taken into income until the funds were applied as directed by the officers of the University. This constituted an acceptable accounting method in accordance with generally accepted college and university accounting practices.

This policy was followed until June 30, 1973, and had the express approval of our auditors. Under the new audit guidelines for colleges and universities,

effective for fiscal year 1973-1974, the policy could no longer be followed. Therefore, unrestricted gifts are now being shown as income for the Schools of Medicine and Dentistry, in the year in which they are received rather than the year in which the officers of the University elect to apply them.

As of July 1, 1973, there was only one gift being treated as "Gifts Not Yet Applied." This \$300,000 gift from a Foundation was designated by the donor to be held in the "Gifts Not Yet Applied" category pending completion of the intent with which the gifts were made.

It is not unusual for donors in different categories to make a partial gift with funds then in hand on a conditional basis toward an eventual propose (for example: a chair an endowed lectureship a memorialized laboratory et cetera) with the much larger amount to come at a later date. Thus, the gift is not yet a restricted endowment but still by designation of the donor not available for any expenditure. Many times these gifts are in the form of stock with instructions that the stock not be sold until the total gift is completed.

"Two reviewers commented on the substantial percentage increase in the Department of Community Medicine and International Health, the Department of Physiology and Biophysics and the Dean's Office as indicating continued programs of expansion." (Page 5, Paragraph 2.)

We would confirm that there is indicated in our distress application substantial increases in the three areas noted above. The expansion of these areas is not indicative of a substantial increase in those departments per se, but they reflect the need for expanded inter-disciplinary approaches to accommodate the significantly expanded student bodies. Faculty members in these three departments while significantly participating in the activities of the departments are to a large extent also serving other areas on an interdisciplinary basis. For example, a Professor of Physiology and Biophysics is charged with conducting ICS programs taught to all entering freshmen and sophomore classes.

It should also be noted that increases in several of these departments resulted from the availability of private foundation support for specific projects and do not reflect any significant increase in University dollars assigned to these respective areas. Those grant funds were given for a specific purpose and personnel employed under this support were advised that their tenure was for the duration of the grant award.

" * * the lack of any substantial effort to increase the income from endowment and investment of the gifts". (Page 5, Paragraph 2.)*

The investment policy of the University is to maximize the income from the investment of endowment funds while simultaneously achieving a steady growth rate in the value of the fund in order to offset the effects of inflation. The endowment funds are managed by the Chase Manhattan Bank.

The University's endowment income could conceivably be increased by investing more funds in income producing securities, but this would result in sacrificing some of the growth potential which is essential to the long term stability of the endowment fund. In fiscal year 1973, of the total university endowment fund of approximately \$33 million, \$8.3 million was invested in bonds, \$18.9 million in common stock, and the remaining \$5.8 million in real estate, mortgages et cetera.

In 1971, the University initiated a 10 year major fund raising campaign (Mandate 81), with the goal of raising \$51 million for phase 1—1971-1975. (Further details are provided in Exhibit 7.)

In fiscal year 1973 the University spent over \$400,000 for fund-raising activities in the Development Office. Approximately 35.8 percent or \$143,000 of this amount was charged to the Schools of Medicine and Dentistry. However, due to these fund-raising activities approximately \$196,000 for the School of Medicine and \$62,000 for the School of Dentistry were raised and applied to operations.

"Why there is so little increase in sponsored programs and Faculty Medicine Services". (Page 5, Paragraph 2.)

The attached Exhibit indicates that between fiscal years 1971 and 1972, the income from Faculty Medicine Services increased by 18.0 percent, and between fiscal year 1972 and 1973, by 71.3 percent. Although this may in dollar terms represent "a little" increase to the reviewer who made the above observation, it undoubtedly demonstrates that substantial efforts are being made by Georgetown University School of Medicine to develop and expand the Faculty Medicine Practice as a source of income.

With respect to sponsored program income, Exhibit 8 demonstrates a 10.9 percent increase between fiscal years 1971 and 1972, and a 26.9 percent increase between fiscal years 1972 and 1973. Although this is not substantial, it does

represent an increase at a time when sponsored program funds available were actually decreasing.

"Why is there no allocation of University surpluses to this condition of distress?" (Page 5, Paragraph 2.)

We would respond that the above stated allegation is not correct and, in fact, over the last six years, the University has contributed more than \$2,600,000 to the operations of its Schools of Medicine and Dentistry. The commitment of these funds to the Medical and Dental Schools have been done in spite of very limited University endowment reserves.

In Fiscal 1973, it should be noted that Georgetown University experienced an overall deficit of \$480,000 and in Fiscal 1972, the University generated revenues over expenditures in the amount of only approximately \$25,000.

We believe that Exhibit — illustrates that the University does in fact allocate surpluses in one area to offset deficits in other areas. In Fiscal 1973, however, it should be noted that there were insufficient surpluses to offset deficits experienced in other University units, thus, resulting in an overall University deficit of of approximately \$480,000.

"Some concluded that there is undue emphasis on additional federal funding as the only alternative." (Page 6, Paragraph 1.)

As indicated in other sections of this response, we have and continue to look toward a dependence on some form of federal financial assistance to our professional health schools. It was our original intent, which we realized with the successful enactment of PL 91-650, that a form of statelike support similar to the type enjoyed by our sister institutions in over twenty states would be necessary if our schools were to continue to exist.

While we would not concede that we have placed "undue emphasis on additional federal funding", we would concede that we have and continue to pursue a mechanism of state-like support which because of the unique position and location of our two health science schools would have to be forthcoming from the state legislature for the District of Columbia—the Congress of the United States. Through the development mechanisms such as PL 91-650 we would not be seeking a total funding source but rather a per student state-like appropriation which would afford our schools to continue to exist and offer a quality education program.

THE GEORGE WASHINGTON UNIVERSITY,
Washington, D.C., March 18, 1974.

HON. ROMANO L. MAZZOLI,
Chairman, Subcommittee on Labor, Social Services and the International Community, Committee on the District of Columbia, U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN MAZZOLI: In response to a request late last week from your office, we are enclosing a presentation which contrasts the methodologies underlying the recently released Institute of Medicine report on the cost of medical education and those document previously supplied to your Committee portraying the fiscal situation at The George Washington University School of Medicine and Health Sciences. Calculations are also provided which reconcile the data previously supplied by us and the average medical student instructional cost recently released in the Institute Study.

The enclosed document has been reviewed with Ruth S. Hanft, Study Staff Director of the IOM Study, and she has expressed a willingness to make comments and observations to your staff if you so desire. Ms. Hanft can be reached at 389-6721.

Sincerely,

JAMES J. FEFFER, M.D.,
Vice President for Medical Affairs.

Enclosure.

RECONCILIATION OF THE COST OF MEDICAL STUDENT EDUCATION AS BETWEEN THE METHODOLOGY EMPLOYED BY THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES AND THE AMOUNTS REPORTED BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The income and expenses reported in Exhibit 1, pages 1 and 2, include only those fiscal items actually recorded in the accounts of the School and of its research activities. They do not include any items of cost or income included in hospital or clinic accounts. It is a fiduciary accounting report of the School as histor-

ically reported and as it is consolidated into the audited financial statements of the University.

The AAMC profile (Exhibit 2) essentially takes the officially reported income and expense of schools of medicine and compares them to national averages on a consistent basis, using certain indexes and ratios (i.e. numbers of students, numbers of faculty) as well as certain nonfiscal data such as MEDCAT scores. The AAMC profile is a comparison of data contained in Exhibit 1.

The report of the Institute of Medicine/National Academy of Sciences¹ sets out a cost per student based on a consistent methodology using program cost-finding techniques. The cost elements and methodology involved in these techniques are so different from those in Exhibits 1 and 2 as to make any direct comparison between them completely meaningless. For example, the total average educational cost per undergraduate medical student reported in the study (\$12,650; range \$6,900-\$18,650) includes the incremental teaching costs incurred in the patient-care setting, which are typically recorded in hospital or clinic accounts. It also imputes a medical school facility cost related to depreciation based on acquisition costs (p. 27 of IOM study). Depreciation is not ordinarily recorded in the accounts of a university medical school, and such costs are not included in our audited financial statements nor in Exhibit 1 or 2. Educational costs experienced by medical schools attributable to other health professionals, for example, physician assistants, are not included in the IOM average cost per medical student.

In Exhibits 1 and 2 the full Sponsored Program cost and income are included, while the IOM study includes only those research costs considered (on a judgment basis) necessary for the education of MD's.

It is not our purpose to draw point-by-point comparisons, but generally the IOM study attempts to cost the milieu necessary for medical student education wherever those costs may be found in an academic health care center—at the patient's bed, in the clinic, at the laboratory bench. The IOM study does not confine itself to costs as traditionally recorded in medical school accounts, but rather reassembles those costs, discards some, adds others, allocates resources used in joint product productions, and arrives at an average cost per medical student based on fairly sophisticated and consistently applied program cost-finding techniques.

ATTACHMENT FOR INDIRECT COSTS ATTRIBUTABLE TO PROGRAMS OTHER THAN M.D. STUDENTS

Although the cost study for the School covering 1972-73 is not yet complete, the preliminary indirect cost pool as determined by principles promulgated under Federal Management Circular 73-8 (formerly Bureau of the Budget Circular A-21) amounts to \$3,071,000. It appears that one method used for allocating indirect costs in some of the 14 schools included in the IOM study was on a total direct cost basis (see page 27 of the study).

Calculation of the Assumed Costs of other than M.D. Instruction:

Sponsored research	\$4, 633, 988
Service income	279, 038
Income from other than M.D. students	419, 153
Subtotal	5, 322, 176
Indirect costs	3, 071, 000
Subtotal	8, 393, 176
Total costs	11, 066, 150
Deducted Direct Costs of M.D. Instruction equals difference	2, 672, 974
Indirect Cost Attribution to Programs other than M.D. Instruction:	5, 332, 176
over 5,332,176 plus 2,672,974 times 3,071,000	2, 045, 572

The IOM study makes a distinction between *educational costs* and *instructional costs*. The average instructional cost for the M.D. degree in the 14 schools studied was \$7,650 (range \$4,000-\$11,000, Table 39). The IOM study also introduces the concept of *net educational expenditure* (p. 89 of study), which offsets total educational costs with research and patient-care income attributable to the educational program.

¹ Report of a Study—Costs of Education in the Health Professions—Parts I and II—January 1974.

Although it would take 4 to 6 weeks to complete a program cost-finding study using the methodologies developed by IOM, assuming staff resources were available, it is possible to approximate the instructional costs of The George Washington University School of Medicine & Health Sciences from the financial data contained in Exhibit 1 for fiscal year 1972-73, which is the year used in the IOM study.

Total recorded costs (from exhibit 1)-----	\$11, 066, 150
Deduct:	
Sponsored research costs-----	\$4, 633, 985
Service income ¹ -----	\$279, 038
Income from other than M.D. students ¹ -----	\$419, 153
Indirect costs attributable to programs other than M.D.	
Students (see Attachment)-----	\$2, 045, 572
Estimated M.D. instructional costs-----	\$3, 688, 402
Number of students-----	516
Estimated M.D. instructional costs per student ² -----	\$7, 148
IOM average-----	\$7, 650

¹ By assuming that income and expense of these programs are equal, we are blending two related but separate concepts discussed in the IOM study, namely, instructional costs and net educational expenditure.

² The deducted cost above does not include the incremental patient-care costs attributed directly to instructional costs (see discussion on pages 68 and 69 of the IOM study). We do not believe that the inclusion of this cost factor—were it known—would materially affect the M.D. instructional costs at The George Washington University Medical Center.

THE SCHOOL OF MEDICINE AND HEALTH SCIENCES

SUMMARY OF ACTUAL AND PROJECTED INCOME AND EXPENSE, FISCAL YEARS 1970-71 THROUGH 1976-77

	1970-71	1971-72	1972-73	Projected Nov. 1, 1973			
				1973-74	1974-75	1975-76	1976-77
INCOME							
Tuition and student fees:							
Medical student							
tuition-----	\$880, 669	\$1, 090, 162	\$1, 375, 270	\$1, 692, 000	\$1, 856, 000	\$2, 100, 000	\$2, 232, 000
Application fees-----	86, 597	112, 325	127, 340	132, 500	139, 000	146, 000	153, 000
Allied health:							
On campus-----			80, 158	158, 000	166, 000	174, 000	183, 000
Off campus-----			116, 474	205, 000	315, 000	332, 000	347, 000
University tuition							
credit-----	84, 834	116, 820	168, 018	170, 000	178, 000	187, 000	197, 000
CGS off campus							
credit-----		55, 422	54, 503	55, 000	58, 000	61, 000	64, 000
Endowment income-----	149, 740	146, 009	144, 107	145, 000	157, 000	158, 000	159, 000
Sponsored programs:							
Direct costs-----	4, 531, 664	4, 719, 332	4, 931, 213	5, 000, 000	5, 315, 000	5, 650, 000	6, 006, 000
Net indirect cost re-							
covery:							
Current year-----	583, 153	764, 584	979, 367	1, 000, 000	1, 063, 000	1, 123, 000	1, 187, 000
Prior years-----			283, 614				
Education and devel-							
opment funds-----	181, 869	175, 873	447, 985	450, 000	478, 000	508, 000	539, 000
Gifts and other income:							
Annual support-----	83, 970	67, 710	47, 881	60, 000	70, 000	85, 000	100, 000
Faculty affiliation-----	187, 106	188, 288	131, 674	189, 000	190, 000	200, 000	210, 000
Division of general							
medicine-----	141, 335	160, 097	279, 038	325, 000	330, 000	350, 000	370, 000
Miscellaneous-----	10, 366	13, 749	67, 680	25, 000	10, 000	15, 000	20, 000
Federal capitation							
grant-----			911, 855	1, 047, 290	1, 141, 000	1, 173, 000	1, 173, 000
Student aid-----			135, 040	135, 000	136, 000	138, 000	140, 000
Total income							
(before distress							
grant)-----	6, 921, 303	7, 610, 371	10, 281, 217	10, 788, 790	11, 602, 000	12, 400, 000	13, 080, 000
EXPENSES							
Faculty salaries-----	2, 398, 000	2, 209, 460	2, 706, 938	3, 192, 000	3, 368, 000	3, 553, 000	3, 748, 000
Nonacademic salaries-----	2, 528, 000	2, 431, 525	2, 901, 403	3, 209, 000	3, 385, 000	3, 554, 000	3, 732, 000
Staff benefits (net of							
leave credits)-----	600, 000	525, 504	583, 943	697, 000	735, 000	775, 000	818, 000
Equipment-----	468, 000	741, 943	769, 158	825, 000	875, 000	928, 000	984, 000
Operation and mainte-							
nance of plant-----	501, 770	626, 534	711, 204	1, 883, 000	2, 100, 000	2, 307, 000	2, 535, 000

THE SCHOOL OF MEDICINE AND HEALTH SCIENCES

SUMMARY OF ACTUAL AND PROJECTED INCOME AND EXPENSE, FISCAL YEARS 1970-71 THROUGH 1976-77

	1970-71	1971-72	1972-73	Projected Nov. 1, 1973			
				1973-74	1974-75	1975-76	1976-77
EXPENSES—Continued							
Other direct costs.....	1,709,690	2,040,381	2,259,901	2,483,000	2,623,000	2,790,000	2,957,000
Medical center and university services.....	871,302	822,316	998,563	1,147,000	1,219,000	1,295,000	1,375,000
Student Aid.....			135,040	135,000	136,000	138,000	140,000
Total.....	9,076,762	9,397,663	11,066,150	13,571,000	14,450,000	15,340,000	16,289,000
Deficit.....	(2,155,459)	(1,787,292)	(784,933)	(2,782,210)	(2,848,000)	(2,940,000)	(3,209,000)
Distress grant received.....	1,900,000	2,100,000	706,459				
Enrollment.....	(445)	(464)	(516)	(564)	(580)	(620)	(620)
Deficit per medical student.....	4,844	3,852	1,521	4,933	4,910	4,742	5,176
Percent of operating deficit to total expense..	(24)	(19)	(7)	(21)	(20)	(19)	(20)

GEORGETOWN UNIVERSITY MEDICAL CENTER,
Washington, D.C., March 20, 1974.

HON. ROMANO L. MAZZOLI,

Chairman, Subcommittee on Labor, Social Services and the International Community, Committee on the District of Columbia, U.S. House of Representatives, Washington, D.C.

DEAR MR. MAZZOLI: The Institute of Medicine (IOM) on behalf of the National Academy of Sciences under date of February 26, 1974, has submitted to Congress a report which was funded under contract with the DHEW to determine the average annual costs of educating students in eight different health science professions. This report bears the title, "Report of a Study: Costs of Education in the Health Professions, Parts I and II."

The IOM study was authorized under the provisions of P.L. 92-157, the Comprehensive Health Manpower Act of 1971 to determine the average annual costs of educating students in the schools of medicine, dentistry, osteopathy, optometry, pharmacy, podiatry, veterinary medicine and nursing.

The Institute of Medicine indicated that Part III of the report describing the technical methodology used to collect and analyze the data will be available within the next two months.

We have had an opportunity to review a copy of the IOM report. More full and detailed analyses will be possible when Part III of the report—the technical description of the methodology—is available. However, from the initial review it is apparent that the IOM study used different methodologies than were used previously by the Association of American Medical Colleges (AAMC) in their cost study work. This is not to say that one method is "better" than another. It is to say, however, that different methodologies have produced a different range of cost results. In light of these differences, it is desirable that we bring this matter to your attention for at least four reasons:

I. To outline the differences in the calculations of the "costs of medical education" between the IOM report and the previous cost study reports (this is done for medicine only because there is no existing previous national comparative cost study for dentistry).

II. To construct an instructional cost per medical and dental student at Georgetown University using IOM methodologies.

III. To identify that under either methodology (IOM or AAMC) the undergraduate medical and dental per student expenditure at Georgetown University is frugal.

IV. To note that the IOM study also emphasizes both the policy that health professional schools are a national resource and the need for state appropriations for such schools.

I. Differences in the Calculation of "Costs of Medical Education" between IOM and AAMC Cost Studies

The IOM study reports the average annual educational cost of medical education at the level of \$12,650 per medical student. This cost is significantly lower than the average total cost per student of \$20,400 per annum, or the \$16,500 per student for Georgetown University both reported by the AAMC. However the variance is easily identifiable. It is attributable to major differences in the methodologies used by the two studies. Examples of these differences are as follows:

1. The IOM study reports an average educational cost per student of \$12,650. Whereas the AAMC study reported an average total cost per student of \$20,400. The parameters applied in the IOM study included only a portion of sponsored program and patient care expenditures. Because the parameters used by both AAMC and IOM are judgmental, there will be national debate as to both the validity of each methodology and the long-range impact of each as a national policy.

2. Both studies differentiate the total cost into three distinct units—instruction, research and patient care. If only the pure instructional costs are examined, there is an average cost of \$8,600 reported by the AAMC study. This cost compares favorably with the average cost of \$7,650 for instruction as determined by the IOM study. The difference in these figures results primarily from the IOM practice of not including hospital related educational costs such as salaries paid to interns and residents by the hospital though the house staff performs an educational function for undergraduate medical students. The IOM study also does not compute a cost attributable to voluntary faculty participa-

tion. If these two costs were included, the figures reported by IOM and AAMC would be in a comparable range.

II. Estimation of the Educational Cost Components per Medical and Dental Student at Georgetown University Medical Center using the IOM Methodology

As indicated earlier complete and definitive information with regard to the exact methodology used by IOM in the calculation of their medical student instructional cost of \$7,650 and per dental student instructional cost of \$8,000 will not be available until Part III of the report is completed.

As a means of calculating a comparative instructional cost per student figure for the Georgetown University School of Medicine which would relate to the \$7,650 average cost reported by IOM we have developed an equational analyses between the results of the AAMC study for our School of Medicine and compared it with the average figures reported by IOM.

There does not seem to be a significant difference between the manner in which the instructional costs were calculated by IOM and AAMC with the exception of the two areas already noted in the previous section. The pure instruction figure reported by AAMC for Georgetown was \$7,100 per student but the average for the twelve schools was \$8,000. Thus, Georgetown is well below the average expenditure per student in this category based on the AAMC study.

If a relationship is drawn between the average instructional cost of \$8,600 reported by the AAMC study and the average instructional cost of \$7,650 reported by the IOM study, a relationship can be developed to the actual instructional cost of \$7,100 reported by the AAMC study for the Georgetown University School of Medicine. Based on this approach it can be determined that under IOM methodology, the Georgetown University instructional cost per student would be \$6,300. If the same calculation is carried into the areas of research and patient care a total educational cost of \$10,200 per medical student can be demonstrated for the Georgetown University School of Medicine (see Exhibit I). This figure of \$10,200 continues to be below the average of \$12,650 reported by IOM.

Due to the absence of a comparative cost study for dental education a similar methodology cannot be used. However, by screening from the descriptive information contained in Parts I and II of the IOM study, we have simulated a cost study using the audited financial operating summaries of the Georgetown University School of Dentistry for FY 1972-73. Using this approach it is possible to report an instructional cost of \$7,899 per dental student per year (see Exhibit II). This amount is less than the average of \$8,000 for dentistry as reported by the IOM study. Also, this figure is well within the range of the instructional cost for similar schools of dentistry. The range for dental schools reported by the IOM is \$5,752 to \$14,198.

To more scientifically determine the education costs per student for schools of dentistry, it would be necessary to utilize the IOM methodology of a complete faculty activity analysis. Georgetown University Medical Center had had experience with this type of study. Future studies of this type are planned.

The methodology used in these calculations was reviewed with Ms. Ruth S. Hanft, Study Staff Director, Institute of Medicine. Given previous Georgetown University School of Medicine cost studies, Ms. Hanft indicated that the per student instructional cost for Georgetown University seemed to be within the range reported for similar private universities included in the IOM study. Ms. Hanft expressed willingness to discuss this subject matter with you or members of your staff if you so desire.

III. Economy of Operation

The AAMC 12 school study ("Undergraduate Medical Education: Elements-Objectives-Costs", Report of the Committee on the Financing of Medical Education, October, 1973) determined a range in 1972 dollars of total annual undergraduate medical education cost per student of 16.3 thousand dollars to 26.4 thousand dollars.

Georgetown University was one of the schools studied in this 12 school representative AAMC group. The total annual cost per student in 1972 dollars for Georgetown University School of Medicine was 16.5 thousand dollars, or third from the bottom in total per student expenditures.

The three least expensive in total expenditure per student in this study were only one hundred dollars (\$100) apart. Georgetown was 16.5 thousand dollars per student as 10th, another school was 16.4 thousand dollars per student as 11th and the 12th school was 16.3 thousand dollars per student in *total cost* per student.

The significance of this frugal total expenditure per student by Georgetown is apparent when the AAMC study indicates that the average total expenditure per student for all twelve schools in the study was 20.4 thousand dollars per student. Georgetown was spending in 1972 dollars \$3,000 per student less than the average of 12 representative schools as studied independently by the AAMC.

Four categories of cost were included in the AAMC study to develop the total annual cost per student. Those categories were instructional cost, research cost, clinical activity cost and other administrative, scholarly and professional activities costs.

Among the 12 schools studied, Georgetown was again third from last in per student expenditure for instructional cost. Georgetown continued well below the average of these twelve schools in expenditure per student for instructional cost.

The AAMC recently issued (February 7, 1974) an Institutional Profile Ranking Report for 92 medical schools (see Exhibit III).

In the profile report Georgetown University School of Medicine was 16th among 92 schools in the quality of students admitted as measured by the MCAT science test administered to medical school applicants.

Although 16th in quality of students, 89 other medical schools expended more funds per student per year than the Georgetown University School of Medicine.

IV. Impact of IOM Recommendations on Georgetown University Request for Consideration of H.R. 11108 (Extension of Previous PL 91-650)

It is a major recommendation of the IOM study that health professions education be funded from a combination of: (1) tuition, (2) gifts, (3) state support and (4) a federal capitation award program. This recommendation supports the request of Georgetown University that some form of state aid is essential for private university schools of medicine and dentistry.

If Congress endorses the recommendations of the IOM study and federal capitation is continued, there would also continue the need for a state-like support in the amount requested under H.R. 11108.

The language of the proposed legislation requests up to \$5,000 for each medical student and up to \$3,000 for each dental student. With the built-in control in the legislation, these provisions are consistent with the recommendations of the IOM study.

I trust that the foregoing information will be of assistance to you and any other members of your Subcommittee. We recognize that the many variables involved in cost study methodology are detailed and therefore at times confusing. We would be pleased to meet with you, members of your staff or in any other way of convenience to you and members of the Committee to provide further information and clarification. Thank you for your continued interest in Georgetown University and both the students and the public we try to serve.

Cordially,

MATTHEW F. McNULTY, JR., Sc.D.,
Executive Vice President for
Medical Center Affairs.

Attachments.

EXHIBIT I

GEORGETOWN UNIVERSITY MEDICAL CENTER

GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

Calculations to simulate Institute of Medicine cost study methodology— Fiscal year 1972-73

Ratio of IOM instructional cost to AAMC instruction cost	1:1.13
Georgetown University AAMC instructional cost	\$7, 100
Georgetown University IOM instructional cost	\$6, 300
Ratio of IOM research cost to AAMC research cost	1:1.98
Georgetown University AAMC research cost	\$4, 300
Georgetown University research cost	\$2, 100
Ratio of IOM patient care cost to AAMC patient care cost	1:1.75
Georgetown University AAMC patient care cost	\$3, 100
Georgetown University IOM patient care cost	\$1, 800
Educational Cost per Medical Student at Georgetown University using IOM methodology	\$10, 200
Average IOM educational cost per medical student	\$12, 650

EXHIBIT II

GEORGETOWN UNIVERSITY MEDICAL CENTER

GEORGETOWN UNIVERSITY SCHOOL OF DENTISTRY

Calculations to simulate Institute of Medicine cost study methodology, fiscal year 1972-73

Instructional and departmental programs-----	¹ \$1,569,000
Capitation grant-----	742,000
Medical center library-----	² 40,000
Student services-----	³ 90,000
Staff benefits-----	⁴ 80,000
Student aid-----	⁵ 100,000
Overhead allocation-----	⁶ 1,123,000
Total-----	⁷ 3,744,000
Divided by 474 students-----	7,899
Average IOM instructional cost per dental student----	8,000

¹ Includes \$949,000 from dental clinic income.² \$47,000 less \$7,000 for use made of the library by researchers.³ \$105,000 less \$15,000 for student services for graduate students.⁴ \$239,000 less percent of staff benefits applicable to sponsored research programs.⁵ \$123,000 less support of graduate students.⁶ \$1,335,000 (includes physical plant \$831,000; general administration, \$236,000; and general institutional, \$241,000) less \$117,000 which is the difference between sponsored program income and expense, less \$95,000 for overhead for graduate programs.⁷ Does not include the \$498,000 sponsored program expenditures.

NOTE.—All figures are taken from the financial operating summary for fiscal year 1972-73. See attached exhibit IIA.

GEORGETOWN UNIVERSITY MEDICAL CENTER, SCHOOL OF DENTISTRY, FINANCIAL OPERATING SUMMARY,
FISCAL YEARS 1973-77

[In thousands]

	Fiscal year—				
	1972-73	1973-74	1974-75	1975-76	1976-77
I. Revenues:					
Tuition and student fees-----	\$1,369	\$1,706	\$1,862	\$1,920	\$2,032
Endowment revenue-----	35	28	32	35	35
Gift revenue-----	62	48	50	55	57
DHEW/BHME financial distress program-----	583	1,775			
Capitation grant-----	890	860	830	820	820
Sponsored programs-----	615	654	655	655	655
Dental clinic revenue-----	949	960	1,010	1,110	1,160
Student aid revenue-----	66	42	42	42	42
Other revenue-----	4	4	4	4	4
Total-----	4,573	5,077	4,485	4,641	4,805
II. Expenditures:					
Educational programs:					
University funded-----	1,569	1,737	1,972	2,125	2,225
Capitation grant funded-----	742	777	744	733	733
Sponsored programs-----	498	533	534	534	534
Medical center library-----	47	61	68	75	85
Staff benefits-----	239	296	326	358	390
Student service program-----	105	103	108	113	120
Student aid-----	123	92	96	200	250
Physical plant operation-----	831	925	999	1,070	1,120
General administration-----	263	274	288	304	319
General institutional-----	241	279	297	327	360
Total-----	4,658	5,077	5,432	5,839	6,136
III. Deficit-need-----			-947	-1,198	-1,331
Enrollment-----	473	517	545	554	554
IV. District of Columbia manpower bill need per student-----	0	0	1,738	2,163	2,403

¹ Application submitted for fiscal year 1947 from DHEW financial distress program.

GEORGETOWN UNIVERSITY, GEORGETOWN UNIVERSITY MEDICAL CENTER,
3800 RESERVOIR ROAD NW., WASHINGTON, D.C.

RESPONSE OF STATEMENTS SPECIFICALLY REFERRING TO GEORGETOWN UNIVERSITY
SCHOOL OF DENTISTRY

Georgetown University School of Dentistry

Since many of the same questions as are asked about the Georgetown University School of Dentistry are the same as where asked about the Georgetown University School of Medicine, I would refer you to certain previous sections applicable to the dental school. In developing our answers to the questions for the School of Medicine, we have attempted where applicable to include information pertinent to the School of Dentistry. As each of you may be aware, these two professional schools with the Georgetown University Medicine Center function in concord with one another and, in fact, share the teaching faculties and facilities of the six basic science departments which are responsible for the two preclinical science years for both dental and medical students. Similarly, both the dental and the medical schools during the time for which we have filed distress applications were dedicated to significantly expanded enrollments in order to meet the critical national shortage of health science personnel, i.e. dentists and physicians.

"Aside from certain specific information this application is the same as submitted by their sister School of Medicine" (Page 6, Paragraph 2)

The application of necessity is the same when it speaks to increased University costs in the area of labor, utilities, nonacademic salaries, Union Contracts with employee groups, fringe benefits including Group Health Insurance, Social Security, D.C. Workmen's and Unemployment Compensation and Retirement Benefits.

"Like the Medical School the applicant points to numerous increases over which they have little control. A number of these have been initiated by the University." (Page 6, Paragraph 2)

On the contrary it has been reaction to unionization of employees, competition in the local labor market, reclassification of certain personnel categories to prevent the loss of essential employees and permit realistic recruitment efforts. Union contract agreements in the Physical Plant Area necessitated extending the same fringe benefit package to all non-union employees to achieve comparability in the University compensation scale.

"With financial distress support over the past years the University has not given any support and none is projected for this or future years." (Page 6, Paragraph 6)

For the most part this comment has been answered in the section relating to the School of Medicine. In Fiscal Years 1971 and 1972, the financial distress awards did fund the deficits occurred in the School of Dentistry, however, in Fiscal Year 1973, the distress award was \$85,000 less than the deficit incurred, this amount being funded by the University.

"Little is included in the application to indicate the School's consideration of alternate potential sources of income." (Page 6, Paragraph 2)

The Administration of Georgetown University has in the past and will continue to identify alternate potential sources of income. As described in detail in the previous section, our efforts to seek an extension of P.L. 91-650—the Medical and Dental Manpower Act of the District of Columbia represents an example of one such effort. If the Secretary's office or the Department of Health, Education and Welfare officials have knowledge of other potential sources of income, Georgetown University would welcome their suggestions and recommendations.

Their fund raising has not been good (Page 6, Paragraph 6)

As described in the previous section, Georgetown University's capital gifts campaign, Mandate 81, with a goal of 51 million dollars is now past the 20 million level with funding of several departmental chairs, two in Basic Science which will support to a large extent Professors in these departments. Georgetown's Annual Alumni Fund which solicits all alumni of the university has been increasing from year to year but fund raising with the objective to support the operating budget of the university is extremely difficult and unrewarding and in this area our efforts, although being pursued in a vigorous manner, have only been modestly successful.

"Very little commitment to improving their present practice plan" (Page 6, Paragraph 6)

The Private Dental Service Practice Plan was initiated in 1957. The Constitution and Bylaws of this Practice Plan has been included as an exhibit in each Distress Application. Like other dental schools, Georgetown's Private Practice Plan is not designed to support significantly the operating costs of the Dental School. Its major objective is to achieve recruitment and retention of outstanding clinical faculty at 30 percent less university salary, because of the opportunity offered to conduct a private practice and supplement their university salary in the 3 one-half days per week provided for in the Practice Plan. At the present time due to critical space shortages the Private Practice Plan is participated in by only 11 clinical faculty.

Further details on the Private Practice Plan including the Organization, Constitution, and Bylaws are submitted as Exhibit 10.

"They have stopped efforts toward cost reduction because their Executive Faculty concluded that further reductions would so adversely affect the quality of education that accreditation would be seriously threatened." (Page 1, Paragraph 1)

The above statement was taken out of context from Part I, Section F, Page 14 of the distress application. The previous paragraph and the portion of the section following the quote above relates to the decision of the Executive Faculty because of the freeze on faculty positions.

This precedes. "The effect of this (freeze) has been to substantially increase the teaching load on the clinical departments because the augmented classes (147 students per class) accepted as a condition of the Capitation and Bonus Award are now entering their clinical years. Because of the reduction in funding of this program, we were not able to implement our staffing plan and as a consequence are understaffed in the clinical departments."

This statement follows the above quote. "Accordingly, this Committee (Executive Faculty) recommended that the School concentrate its attention on increasing revenues and execute no further cuts in faculty, staff, or program. Thus, we feel that every austere action consistent with the maintenance of quality education has been taken and every effort is being made to increase income and reduce expense. These efforts will be continued indefinitely."

"Other reviewers echo comments about expanding the Dental Clinic income" (Page 7, Paragraph 1)

The Dental Clinic Income has been increased as shown below :

1970-71	-----	783, 000
1971-72	-----	884, 000
1972-73	-----	949, 000
1973-74 (estimated)	-----	960, 000

Thus the Dental Clinic Income has been expanded from FY 1971 to FY 1974 by 22.6 percent or \$177,000 dollars. As of January, 1974, the Dental Clinic Income has increased by 12% as compared with January, 1973.

These increases have been achieved in a period when the Cost of Living Council has restricted overall increases in dental fees to 2½%. This has very recently been increased to 4% but still remains considerably behind cost increases allowed in other areas of the economy.

Other reviewers echo comments about . . . some help from the parent university (Page 7, Paragraph 1)

This comment has been responded to in detail in the previous section. To reiterate briefly—the University has insufficient unrestricted endowment income to cover a deficit of the magnitude of that experienced in recent years by the Schools of Medicine and Dentistry. The majority of the endowment income is restricted to student aid, scholarships, Chairs and Lectureships.

There is reference by all reviewers that no plan has been presented to eliminate or substantially reduce the imbalance except obtaining additional federal assistance

As previously described a plan has been submitted to seek legislation to extend P.L. 91-650—The Medical and Dental Health Manpower Act of the District of Columbia. If this endeavor is successful, the Georgetown University School of Dentistry will have a source of state-like support similar to that enjoyed by the majority of private dental schools throughout the nation.

Other plans have been prepared and discussed, for example increasing tuition to \$6,000-\$7,000 per year. Such plans have not been included in the distress applications as at the current time they do not represent a realistic solution.

EXHIBITS

NOTE.—Exhibits 1 and 2 appear at the beginning of the response immediately following the introductory statements by Matthew F. McNulty, Jr., Sc.D.

EXHIBIT 4

GEORGETOWN UNIVERSITY MEDICAL CENTER—DISTRESS FUNDS RECEIVED BY GEORGETOWN UNIVERSITY, SCHOOLS OF MEDICINE AND DENTISTRY

	Received, fiscal year—			
	1971 actual	1972 actual	1973 actual	1971-73 total
School of Medicine.....	2,211,000	1,644,240	1,418,825	5,274,065
School of Dentistry.....	1,089,000	942,609	583,391	2,615,000
Total.....	3,300,000	2,586,849	2,002,216	7,899,065

EXHIBIT 5

BASIS FOR ALLOCATION FOR COSTS IN THE BASIC SCIENCE DEPARTMENTS TO THE MEDICAL AND DENTAL SCHOOLS IN THE RATIO OF 60:40 PERCENT RESPECTIVELY

	1970-71		1971-72		1972-73		1973-74	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Number of freshman and sophomore students:								
School of Medicine.....	300	56.3	383	60.5	417	60.7	413	58.5
School of Dentistry.....	233	43.7	250	39.5	270	39.3	293	41.5
Total.....	533	100.0	633	100.0	687	100.0	706	100.0

EXHIBIT 6

GEORGETOWN UNIVERSITY MEDICAL CENTER—REMEDIAL ACTION TO REDUCE COSTS

In 1969-70 it was clear at Georgetown University that a laissez-faire faculty staffing development for the schools and hospital of the Medical Center was no longer economically valid. As an economy measure strictly enforced since that time, no additional faculty positions have been permitted against University funds for the Schools of Medicine and Dentistry.

An analysis of all budgeted non-sponsored program positions for fiscal year 1969-70 and fiscal year 1972-73 was conducted for the School of Medicine. This analysis reveals a reduction of 3 academic positions from FY 69-70 through FY 72-73. During this time period enrollment in the School of Medicine increased from 473 students to 705 students and will stabilize at approximately 820 students by September, 1974.

A similar analysis of the School of Dentistry for budgeted nonsponsored program positions reveals a reduction of 4 academic positions from FY 69-70 to FY 72-73. During the same period, enrollment in the School of Dentistry increased from 406 students to 470 students and will stabilize at approximately 590 students by September, 1976.

These reductions and continued containment of University financed positions of Medicine and Dentistry result from a conscious program of cost reduction for the Schools of Medicine and Dentistry.

Including faculty financed from all sources, these constant and "most reprehensible" (by faculty definition) economies have resulted in a 30% increase in the student to faculty ratio for the School of Medicine. This ratio of students to faculty will increase even further for faculty strength will be increased only minimally as supported for the term of any sponsored program support while the medical student enrollment increases to approximately 820.

This same model of economy of scale benefit as a meaningful effort to reduce costs applies to the School of Dentistry.

It is difficult to obtain comparative data to document this economy of scale that has been realized. However, recently (Vol. 16, No. 17, April 25, 1973, *Drug Research Reports*—Page 3, "Dartmouth Growth to Continue") the Blue Sheet indicated that Dartmouth University with many fiscal problems for financing its school of medicine had authorized for a three year school curriculum of 64 students per class (192 students) a university supported "core" facility of 53 and "additional members up to a total of 110—supported by sponsored research or service income."

It is not clear whether the two foregoing figures produce a total of 110 or a total of 163 faculty members for 192 students. Also there are limitations on comparing a three year program with a four year program as well as many other limitations. However, it does seem fair to say that, no matter how compared and using the lowest faculty figure of 110, there is a significant economy of scale realized at Georgetown University School of Medicine based on the student to faculty ratio. Other informal studies relating to other university (private and public) medical school-dental school ratios have documented the same achievement by Georgetown.

MANDATE 81

The Seventies must be a decade of meaningful growth for Georgetown University, bringing increased educational and moral impact, along with constructive—yet selective—expansion. To realize this goal, our university leaders began in 1971 to plan a ten-year development program—appropriately named MANDATE 81.

To meet the needs of MANDATE 81 during the first five years of the program, Georgetown must raise \$51.3 million from private sources. This means that we must ask substantial numbers of alumni, parents, friends, foundations and corporations to make a major investment in the continued greatness of Georgetown University.

This investment will provide new strength to Georgetown—the financial assets to support scholarships, endowed chairs, library resources, an academic learning resource center, a concentrated care center hospital, a swimming pool, and enrichment programs to support the life of the university.

MANDATE 81 will bring major financial support *in addition* to the annual alumni fund. Each of these sources of support is essential to Georgetown. The annual fund undergirds the yearly operation of the university. But in addition to this Georgetown must raise a substantial sum which will greatly increase our endowment.

This increase in endowment is needed to match the dramatic rise in costs that has taken place during the past ten years. From 1962 to 1972 the yearly expenditures of Georgetown have risen from \$21,863,000 to \$68,405,000; most of this increase is the result of higher costs—not expanded programs. Only through sound and prudent financial management has Georgetown been able to remain solvent. In fact, during the past two years the annual budget has actually shown a modest surplus.

However, our austere budget has forced us to defer many additions and improvements that Georgetown needs. The first phase of MANDATE 81 will provide the financial resources to keep Georgetown strong and vibrant. MANDATE 81 will permit Georgetown to continue as one of the nation's leading universities.

MANDATE 81 is already off to a very good start. During the past year we have shared our case for support with key alumni, friends, foundations and corporations. Already we are more than 25 percent of the way toward our goal. We are now more convinced than ever that MANDATE 81 is a sound program.

We will continue to take MANDATE 81 to those around us. Hundreds of alumni and friends have been involved in sharing our message. Eventually—prior to 1975—every alumnus and friend of Georgetown will have been given an opportunity to contribute to MANDATE 81.

Volunteer leadership and participation has been—and will continue to be—the key to the success of MANDATE 81. Today over 500 individuals are members of Georgetown's National Development Committee, professionals from all walks of life who give generously of their talent and time to advance this important program. The chairman of the Committee is The Honorable J. Edward Day, former Postmaster-General of the United States and a distinguished Washington attorney.

Georgetown must look to scores of alumni and friends for volunteer leadership during the months ahead. Virtually every large gift to Georgetown—from any source—is the result of the efforts and dedication of at least one volunteer.

MANDATE 81 is a program committed to strengthening and expanding the financial base of Georgetown University. By doing this, we strengthen the educational impact of the institution. We believe that our goals are sound and that the volunteer leadership supporting MANDATE 81 will insure its success.

THE PRIORITIES

SCHOLARSHIPS AND STUDENT AID—\$10,000,000

For many individuals, the most satisfying gift they can make to a university is one that assures support for an academically talented young person who could not continue his education without financial assistance.

If Georgetown is to continue to attract the most promising students, its financial aid program must be bolstered radically. At the very least, Georgetown must double its available scholarship funds in the next few years.

Currently, the University grants \$2.2 million annually in student financial assistance. Of this total, roughly \$800,000 must come from current operating revenues, since income from student aid endowment totals only \$1.4 million.

Georgetown, therefore, seeks an additional \$10 million in endowment; not only to offer more scholarships, but to increase the amount funded through endowment.

ENDOWED CHAIRS AND LECTURESHIPS—\$11,000,000

The ability to attract and hold distinguished scholars who are renowned in their respective fields is absolutely essential to Georgetown's continued academic achievements.

As a private university, Georgetown can meet this challenge only if its key professorships and lectureships are increasingly supported through income earned from permanent endowment, rather than from current operating revenues.

During Phase I of MANDATE 81, the University is seeking a minimum of \$11 million in endowment to establish seven Distinguished University Chairs, nine University Professorships, and sixteen University Lectureships throughout all of its schools.

Permanent funding of these positions calls for substantial principal. Specifically, \$700,000 is required to endow a University Professorship, and \$100,000 for a University Lectureship.

The endowment income of each will pay the salary of the appointed professor or instructor and provide added funds for scholarship research and publication in his field.

CONCENTRATED CARE CENTER—\$6,000,000

The addition of a Concentrated Care Center hospital will enhance Georgetown's already long-established reputation in the field of medicine and health care—and will offer a practical alternative approach to traditional health care services.

About 20 percent of hospital patients are in serious condition, needing intensive round-the-clock care. The rest are hospitalized to undergo tests, to convalesce, or to receive treatment for chronic ailments. Georgetown's planned Concentrated Care Center will offer the latest medical techniques and services to those needing them most—the acutely ill.

The modern Center will incorporate expanded operating, emergency and recovery room facilities, along with special electronic monitoring devices for respiration, heartbeat, blood pressure, and temperature. Instant warning systems will alert nurses and doctors to a crisis, alleviating much pain and critical danger.

The Concentrated Care Center will cost \$21.8 million, of which \$6 million must be raised from private sources.

PRESIDENT'S FUND—\$1,000,000

In a fine university, ideas are generated that deserve being pursued but for which no budgeted funds are available. Speakers, art exhibits and other programs that enrich the life of the campus frequently become available on short notice—as do important collections and useful real estate. The University should be able to capitalize on these opportunities when they arise.

That such opportunities may not be lost, and to enable the president to give a timely and encouraging response to them, Georgetown seeks \$1 million to establish The President's Fund. The very existence of such a fund can in itself be a powerful stimulus to thought and ingenuity.

ADDITIONAL LIBRARY RESOURCES—\$1,000,000

The intellectual vigor of any great university is, in large measure, nurtured by the quality and extent of its libraries.

Georgetown has made great strides in recent years in the development of its library facilities, with the addition of the Joseph Mark Lauinger Memorial Library on the Main Campus, the John Vinton Dahlgren Library at the Medical Center, and the new University Law Center Library.

Still, the need for materials for those libraries continues to increase. By 1980, Georgetown must acquire a minimum of 375,000 additional volumes and 300,000 more microtexts to undergird adequately its undergraduate and graduate programs.

Beyond its current budget allocations for libraries, Georgetown needs an additional \$1 million by 1975 to establish a permanent Library Resources Purchase Fund.

MAINTAINING PRESENT PROGRAMS—\$8,000,000

Sustaining the depth and quality of Georgetown's present academic programs is a paramount objective of MANDATE 81.

The University does not intend to become a large research center, or to undertake extensive government or private industry commitments which might deflect its current concentration on undergraduate and graduate teaching. There was a time when every graduate of Georgetown left the campus with a Bachelor of Arts degree and a major in philosophy. Today, students may choose from among 25 or more different majors.

For each department, salaries of present faculty must be kept at competitive levels, the latest equipment and materials must be purchased, and classrooms and buildings must be maintained.

Substantial new resources—some \$8 million—are needed to maintain the quality of Georgetown's present programs. These added funds will be used both for endowment and current operations.

ACADEMIC LEARNING RESOURCES CENTER—\$7,000,000

Among the top-priority physical needs at Georgetown is a multipurpose Academic Learning Resource Center, a building that will be the instructional heart of the campus.

The Center will provide classroom and lecture halls, offices, seminar and conference rooms, flexible space for theatrical productions, students study carrels, and audio-visual and programmed learning complex.

The latter will incorporate the latest educational technology equipment, including closed-circuit television, videotapes, computer terminals for programmed instruction, and other advanced audio and electronic equipment.

UNIVERSITY BUILDING ENDOWMENT FUND—\$5,000,000

MANDATE 81 follows years of extensive construction at Georgetown, especially during the period 1966-71, when six new structures at the Medical Center, on the Main Campus, and in the city's judiciary district were erected. Built at a cost of over \$37 million, these buildings were financed by a combination of private gifts, federal grants, and federal loans.

Georgetown must repay these long-term low-interest loans and meet the added costs of maintaining and operating the new structures—and must do so in a way that well not devour the University's annual operating income.

Consequently, as an important facet of MANDATE 81, Phase I, we are seeking a minimum of \$5 million to establish the University Building Endowment Fund. After careful investment, income from this fund will be used to liquidate current loans and obligations.

50-METER INDOOR SWIMMING POOL \$1,500,000

Georgetown has, for a number of years, benefited from a well-conceived program of intercollegiate athletics, concentrating its major efforts on basketball and track, with sufficient emphasis on minor sports to engage the interest and enthusiasm of smaller groups.

One long-standing need, however, has been a swimming pool—a facility that could be used for top-flight competition as well as meeting the year-round recreation requirements of large numbers of students and faculty.

As the first part of a new athletic-recreation complex, Georgetown plans to build a 50-meter indoor swimming pool with seating for 400 spectators.

The entire cost must come from private sources, and Georgetown will name the facility in honor of a donor who contributes at least one-half of the total cost.

RESTORATION OF THE HEALY BUILDING—\$800,000

The Healy Building is a structure that deserves and is now undergoing renovation. In its more than 80 years, this distinctive and dominant structure on the main campus has served the University in a number of roles.

Moving the main library from Healy to the modern Lauinger Library in 1970 has made it possible to free extensive areas of this venerable building for other uses.

The essential character of the interior—gracefully rounded brick arches and high ceilings—is being preserved. The ground floor will accommodate a number of student activities, the first floor additional classrooms and work area for the Fine Arts Department, the second floor, both much needed administrative offices and painting and sculpture studios.

During Phase I of MANDATE 81, the first stage of the renovation is being undertaken at a cost of \$800,000. The overall, long-range renovation will cost \$2 million.

MANDATE 81 GIFT TABLE

The priorities and programs outlined here represent a major investment in Georgetown University. The goal of MANDATE 81, Phase I, is \$51.3 million. To reach it by the end of 1975, Georgetown must secure a specific number of pledges and gifts at various levels. The MANDATE 81, Phase I, "Gift Table" shown here outlines what must be achieved at each level.

Gift level	Minimum number of donors needed	Amount to be raised at each level
\$1,000,000 or more.....	10	\$14,000,000
\$500,000 or more.....	12	7,000,000
\$100,000 or more.....	80	10,500,000
\$50,000 or more.....	75	5,000,000
\$10,000 or more.....	500	7,000,000
Under \$10,000.....	12,300	7,800,000
Total.....	12,982	51,300,000

EXHIBIT 8

GEORGETOWN UNIVERSITY MEDICAL CENTER, SCHOOL OF MEDICINE—INCREASE IN FACULTY MEDICINE SERVICES AND SPONSORED PROGRAM INCOME, FISCAL YEARS 1971-73

[Dollar amounts in thousands]

	1970-71	Percent of increase	1971-72	Percent of increase	1972-73
Faculty medicine services.....	\$1,084	18.0	\$1,279	71.3	\$2,191
Sponsored programs ¹	7,969	10.9	8,835	26.9	11,210

¹ Includes income for capitation and P.A.P.

EXHIBIT 9

STATEMENTS OF CURRENT FUND REVENUES AND EXPENDITURES FOR THE YEARS ENDED
JUNE 30, 1973 AND 1972

	1973	1972
Revenues:		
Educational and general:		
Student tuition and fees	\$22,598,951	\$19,474,038
Endowment and other investment income	922,167	1,160,712
Gifts	977,362	517,525
Sponsored programs	14,671,718	14,444,355
Federal grant assistance for medical and dental education (note 9)	6,035,196	5,298,027
Sales and services of educational departments, dental clinic	949,135	883,665
Organized activities relating to educational departments	95,894	107,656
Other	831,284	391,074
Total educational and general revenues	47,081,707	42,277,052
Student aid	1,037,362	1,099,409
Hospital	22,325,271	20,741,039
Auxiliary enterprises	4,562,679	4,509,150
Total revenues	75,007,019	68,626,650
Expenditures:		
Educational and general:		
Instructional and departmental research	16,606,534	14,179,752
Organized activities relating to educational departments	1,302,268	1,153,985
Sponsored programs	13,148,200	13,037,651
Libraries	1,701,540	1,430,285
Student services	1,649,790	1,171,832
Operation and maintenance of physical plant	4,442,954	4,020,106
General administration (note 2)	1,842,836	1,656,231
Staff benefits	2,119,163	1,867,455
General institutional expenses (including debt retirement for 1973 of \$77,122 and for 1972 of \$79,440)	2,829,798	2,411,763
Total educational and general expenditures	45,643,083	40,929,060
Capital additions, replacements and permanent improvements	331,844	503,009
Student aid	2,455,233	1,967,677
Hospital (note 2)	22,199,637	20,619,803
Auxiliary enterprises (including debt retirement for 1973 of \$165,878 and for 1972 of \$159,561)	4,862,123	4,581,678
Total expenditures	75,491,920	68,601,227
Revenues over (under) expenditures	(484,901)	25,423

EXHIBIT 10

CLINICAL PRACTICE PLAN

A copy of the Intramural Practice, Constitution and By Laws is attached.

1. The plan has been in effect since 1957.
2. There are no faculty contracts in the dental school. Faculty members who wish to participate in intramural practice are allowed three half days out of ten half days in a 5 day week for intramural practice.
3. It can be noted by the percentage that the more gross income a clinical faculty member receives the more he will benefit from his percentage of that income.
4. The income to the individual practitioner is limited to doubling his salary from the School of Dentistry.
5. All departments are eligible to participate. The space available for practice limits the number of practitioners to 14.
6. The distribution of income is accomplished by the formula shown in the Constitution and By Laws. Operating income and costs of the Private Dental Clinic are recorded in a single cost account in the school. Any operating surplus is applied directly to the overall operative expenses of the school.
7. Funds generated from this program are used to support the operating costs of the school.
9. The billing is done by employees of the school.
10. The distribution of income is by the formula in the Constitution and By Laws.

ORGANIZATION—INTRAMURAL PRIVATE DENTAL SERVICE, JANUARY 1, 1967

I. DEFINITIONS

A. There will be the following divisions of practice in the Private Dental Service.

1. General Dentistry.
2. Oral Surgery.
3. Periodontics—Endodontics.
4. Pedodontics.
5. Orthodontics.
6. Prosthodontics.

B. Each division is separate and does not encroach on the other.

1. The General Dentistry division performs all types of dental treatment. However, it is anticipated that patients in need of Oral Surgery, Orthodontics, Periodontics, Endodontics and Pedodontics will be referred to the specialists in these divisions.

2. Those in Oral Surgery, Orthodontics, Prosthodontics, Periodontics, Endodontics and Pedodontics are limited to the practice of their specialty as prescribed by the respective speciality boards. Periodontics and Endodontics are combined in one practice. General anesthesia may be administered only under the supervision of the Oral Surgery participants.

3. Oral Diagnosis or Consultation. In cases where a routine restorative dentistry diagnosis is to be devised it should be done by one in the General Dentistry division. In cases requiring more specialized diagnosis, any or all divisions may be called together, or a special diagnostician or consultant may be called.

II. ADMINISTRATION

The ultimate authority over the Intramural Service shall rest with the Dean of the Dental School. The Dean has delegated administrative supervision of the area to the Director.

III. PARTICIPANTS

Participants are those full-time faculty members of the School of Dentistry approved for participation by the Dean, who have indicated a willingness to abide by the rules and regulations in current use. Participants must be legally licensed to practice dentistry in the District of Columbia and must secure their own professional liability insurance.

IV. PATIENTS

Patients are those referred to a specific participant or those requesting treatment in the Private Dental Service. No patient registered in the Georgetown University School of Dentistry Clinics will be taken in the private practice of any faculty member for a period of one year from the date of the last appointment or treatment at the Dental School, without written permission from the Dean. Patients treated in the Private Dental Service cannot be accepted as patients in the school clinics for a period of one year from the date of the last appointment or treatment in the Private Dental Service, without written permission from the Dean.

V. EQUIPMENT, MATERIALS AND SUPPLIES

All equipment, materials and most supplies will be furnished on requisition approved by the Director and the Dean and shall remain the property of the School of Dentistry. Each participant is expected to exert the utmost care of the property and is expected to utilize all equipment, materials and supplies on hand before requesting different ones (to be ordered). Gold, other casting metals and artificial teeth will be furnished by the participant and their cost entered as a laboratory expense on the monthly tabulation sheet which is sent to the Dean.

VI. TIME

Nine-11 $\frac{1}{4}$ hours per week (depending upon individual schedules) may be devoted to Intramural Practice during school or clinic hours, to be between 9:00 a.m. and 12:45 and 1:30 p.m. to 4:30 p.m. This time must be approved by the Dean or the Department Chairman. The Director should be consulted regarding

availability of an operator. Intramural practice may be engaged in during specified additional hours but not during the hours that the Dental School is in operation, and provided it does not interfere or conflict with school duties.

VII. TECHNICIANS AND ASSISTANTS

Laboratory work may be sent to a commercial laboratory or be done by the school laboratory technicians; however, if by School laboratory technicians, the work may not be done during school hours. X-rays may be made by the participant, an assistant, or X-ray technician. The fees paid by the participant, for laboratory services and to the X-ray technician (not employed by the P.D.S.) are to be deducted from the gross income. It will be the responsibility of each member to employ and regulate the schedule and duties of their own dental assistant who will be responsible to the doctor or doctors who employ her. Salaries, minimum hours per week, and the amount of vacation and sick leave will be established by the University. It is expected that a dental assistant hired by two or more doctors would divide her time equally among them or as agreed upon by the doctors involved. The doctors may release and assign dental assistants to perform community duties as they see fit. A full time assistant who is employed by or responsible to only one doctor will be expected to devote one half of her working time to community duties, this assignment to be decided upon mutually by her doctor and the Director.

Student assistants and regular assistants utilized during additional hours will be paid for by the individual participants. Their salaries are entered as a cost and are remitted to the University at the time of monthly settlement.

VIII. FEES

All fees are determined by the participants. Each remittance in the form of checks is to be made out in the doctor's name. All fees are to be collected by an assistant or other designated personnel, and recorded in the ledger provided by the Director.

IX. DIVISION OF INCOME

The adjusted gross income of each participant is to be divided according to the following scale:

Ann. cum. adj. gross		Doctor		G.U.	
		Percent	Amount	Percent	Amount
Category:					
I.....	1st \$5,000.....	60	\$3,000	40	\$2,000
II.....	2d \$5,000.....	65	3,250	35	1,750
III.....	3d \$5,000.....	70	3,500	30	1,500
IV.....	4th \$5,000.....	75	3,750	25	1,250
V.....	5th \$5,000.....	80	4,000	20	1,000
VI.....	Remainder.....	80		20	

The annual cumulative adjusted gross is tabulated beginning July 1 each year.

The *Adjusted gross income* is the total collected income (gross) for a given period reduced by certain allowable costs which have been paid by the participant during this period.

Allowable costs (expenses) are the following:

(a) *Fixed expenses*.—to be deducted at the rate of \$20.00 per month; these include professional liability insurance, D.C. Dental Society dues, and D.C. Dental License fee.

(b) *Assistant Costs*.—Costs of assistants utilized during additional hours at the following scale: student assistants \$1.50 per hour; regular assistants—\$2.00 per hour—these are the maximum rates which are deductible.

Only one assistant may be utilized by a participant at a time and the total cost per year may not exceed a fixed amount (to be determined). Costs may be accrued only during the time the assistant is actively engaged in assisting the participant in the Private Dental Service.

The amount due assistants is remitted to the Treasurer's Office together with G.U.'s portion of the adjusted gross.

(c) *Laboratory Costs*—Copies of monthly statements from laboratory must be submitted.

(d) *X-rays made by technician*—(not employed by the Private Dental Service.

(e) *Gold and Artificial Teeth*—purchased by the participant and which are not included in laboratory bills.

Copies of statements for c, d, and e above must be submitted with the monthly tabulation sheets.

Monthly tabulation and settlement of accounts are to be completed within 10 days after the close of the month in question. All costs by the participant directly to the recipient except the after hours assistant cost which is paid to the Treasurer of the University.

Initiation of this system on 1 January 1967 necessitates that *all* accounts of the calendar year 1966 be settled by 10 January 1967. The initial cumulative adjusted gross of the participant will be calculated from 1 July 1966 to December 31, 1966. Thereafter, all cumulative figures will begin on the first day of the fiscal year (1 July) and terminate on the last day of that fiscal year (June 30).

X. ADVISORY COMMITTEE

An Advisory Committee composed of the participants in the Intramural Program, shall consider problems which arise. The Dean shall be a member of the Committee, and shall be the chairman, or he may delegate the chairmanship to another person. The Dean shall have final approval or disapproval of all administrative matters concerned with governing the clinic. Changes in this "organization" shall be made only with the approval of the President of the University or his representative.

REGULATIONS—INTRAMURAL PRIVATE DENTAL SERVICE, JANUARY 1, 1967

I. ASSIGNMENT OF PATIENT PARTICIPANTS

Patients requesting the dental services of a specific participant will be assigned to that participant for treatment. He may:

- (a) accept and treat the patient (within the limitations set forth)
- (b) refer the patient to another member of the Private Dental Service (or other practitioners) or
- (c) refer the patient back to the desk for re-assignment.

Patients requesting routine dental treatment will be assigned on an equitable "turn" basis to the participants in the General Division. The "turn system" will also apply to the assigning of those patients who request or obviously are in need of a specialty service. Patients requesting or needing the services of a general dentist *and* one or more specialist, and those for whom the exact needs cannot be ascertained will be assigned initially to a participant in the General Division. The "turn system" of assigning patients does not apply to those who request the services of a specific participant or to those referred by other participants.

II. X-RAYS

X-rays may be taken by the participant, an assistant, or X-ray technician, at the discretion of the participant. X-rays taken by a technician not employed by the P.D.S. will be paid for by the participant requesting them and this cost will be entered on his financial statement as an expense.

III. HOURS

Those full time faculty members selected by the Dean as participants in the Intramural Private Dental Service will be released from their regular school duties for this purpose, three half days per week, Monday through Friday, during the hours of 9-12:45 and/or 1:30-4:30. The times selected will be determined by the Department Chairman or the Dean, and the Director.

There are two divisions of practice hours available:

- 1. *Regular hours*
- 2. *Additional hours.*

Regular Hours: Mon.-Fri. 9-12:45 and/or 1:30-4:30. Each participant is limited to 3 blocks of 3 half days each (9-12:45 and/or 1:30-4:30) Maximum per week: 9-11 hrs. depending upon the following schedule:

Morning block(s) (9-12:45)	Afternoon block(s) (1:30-4:30)	Total regular hours/
3	0	11 $\frac{1}{4}$
2	1	10 $\frac{1}{2}$
1	2	9 $\frac{3}{4}$
0	3	9

Additional Hours: Mon.-Fri. 4:45-7:45—Sats. 9-12 or 12:15-3:15.

By arrangement with the Director, the Private Dental Service will be available for *additional* practice during the following hours but not during any time that the Dental School is in operation:

Each participant is limited to 3 blocks of 3 hours each plus one block of three hours on alternate Saturdays.

Maximum per week: 9 or 12 hours (alternately). There are seven 3 hour blocks available each week. Each member selects 3 blocks, the senior member receiving preference. The one remaining block of three hours will be assigned on a weekly alternating basis.

In order to qualify for practice during these *additional hours*, the following is necessary:

1. Arrangement with the Dean and/or Director.
2. Arrangement (by mutual agreement with other participants assigned to that operatory) of the schedule of additional hours.
3. Provide their own dental assistant (student or other).
4. Assume complete responsibility for preparing the area used for those participants who may utilize them next. When a participant's regular afternoon hours (1:30-4:30) and additional hours (4:45-7:45) are scheduled consecutively, he may continue without interruption from 1:30 p.m. to 7:45 p.m.

(The 4:30-4:45 p.m. period is reserved for preparation of the operatory for use by a different participant. Participants are encouraged to allot a portion of their assigned time for the treatment of their emergency patients.

During Holy Days and school recess periods (Thanksgiving, Easter and Christmas) the Private Dental Service will be available for practice during *Regular hours* only—Monday through Friday 9-12:45 and 1:30-4:30.

During these times each participant may practice during his scheduled *Regular hours* (Monday-Friday 9-12:45 and 1:30-4:30) and during any other *Regular hours* that his *assigned operatory* is not being utilized by the other participant. A schedule for this additional use of the shared operatory should be agreed upon by the participants involved, and the Director should be informed. To insure efficient operation of the area, it is requested that participants notify the Director of their intent to practice during these periods at least *one week* in advance of the first day involved.

During the summer vacation (July) the Private Dental Service is also available for practice during *Regular Hours*, Monday-Friday 9-12:45 and 1:30-4:30. Participants must inform the Director of the time they wish to practice at least *two weeks* in advance of the first day of this period. During this time the regular schedule will be suspended and replaced by a special vacation schedule. In order to allow each participant to use his own assigned operatory, it will be necessary for the sharing participants to arrange their schedule in such a way that the assigned operatory is available to each participant for at least 50% of the total *Regular hours* available.

IV. EMERGENCIES

Bona fide emergencies may be seen at any time but they would not be expected to occur with any great frequency. It is requested that some portion of each regular practice period be set aside for this purpose and that no regularly scheduled patients be informed to report between the hours of 12:45-1:30, after 7:45 p.m. or before 9 a.m. The Private Dental Service is closed during the following periods: All legal holidays (exact dates to be posted by the Director). Between the Hours of 12:45-1:30 weekdays, 12 to 12:15 Saturdays. Before 9 a.m. and after 7:45 p.m. any day, and after 3:15 p.m. Saturdays.

V. USE OF OPERATORIES, OTHER THAN THOSE ASSIGNED

For the efficient operation of the entire area it is imperative that participants confine their practice to the operatory assigned to them. The use of one operatory other than the one assigned may be permitted under the following situations:

- (a) Bonafide emergencies, and,
- (b) Availability of unscheduled operatory which will be vacated and prepared prior to its scheduled use.
- (c) The participant must furnish his *regularly assigned* assistant or student assistant for the operatory.

Please inform the Supervisor or her designee so that scheduled use of the room may be ascertained.

VI. TECHNICIANS AND ASSISTANTS

As far as possible, a receptionist and one other employee will be available during all regular hours (Monday thru Friday) from 8:30-4:30. The chairside assistants schedule and duties will be under the auspices of her doctor or doctors, except as stated in section VII—Organization.

During the lunch period 12:45-1:30 the receptionist should serve only that function. During all additional hours a student assistant will serve as receptionist, stock dispenser and the person responsible for securing the entire area at 7:45 p.m. weekdays and 3:15 p.m. Saturdays.

Laboratory work may be sent to a commercial laboratory or be done by the School laboratory technicians; however, if by School laboratory technicians, the work may not be done during school hours. X-rays may be made by the participant, an assistant, or X-ray technician. The fees, paid by the participant, for laboratory services and the X-ray technician are to be deducted from the gross income. Student assistants will be paid for by the individual participants. Their salaries are monthly settlement.

VII. SENIORITY

Seniority of participants will be established according to the length of practice in the Private Dental Service. When some decisions must be made, all other factors being equal, the participant with the longest service will be given preference.

VIII. DIVISION OF INCOME

The adjusted gross income of each participant is to be divided according to the following scale:

Ann. cum. adj. gross	Doctor		G.U.	
	Percent	Amount	Percent	Amount
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