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RURAL HEALTH SERVICES IN IOWA

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KANSAS STATE UNIVERSITY

HEARINGS

BEFORE THE

SUBCOMMITTEE ON RURAL DEVELOPMENT

OF THE

COMMITTEE ON AGRICULTURE AND FORESTRY

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

- GRIMES, IOWA, OCTOBER 12, 1976
- TREYNOR, IOWA, OCTOBER 14, 1976
- MOVILLE, IOWA, OCTOBER 17, 1976
- TRAER, IOWA, OCTOBER 18, 1976
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HEARINGS

SUBCOMMITTEE ON RURAL DEVELOPMENT

OF THE

COMMITTEE ON AGRICULTURE AND FORESTRY

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RURAL HEALTH SERVICES IN IOWA

TUESDAY, OCTOBER 12, 1976

U.S. SENATE,
SUBCOMMITTEE ON RURAL DEVELOPMENT
OF THE COMMITTEE ON AGRICULTURE AND FORESTRY,
Grimes, Iowa.

The subcommittee met, pursuant to notice, at 10 a.m. in the American Legion Hall, Hon. Dick Clark (chairman of the subcommittee) presiding.

Present: Senator Clark.

STATEMENT OF HON. DICK CLARK, A U.S. SENATOR FROM IOWA

Senator CLARK. The hearing will come to order. I would like to welcome you to this hearing of the Rural Development Subcommittee of the U.S. Senate Committee on Agriculture and Forestry.

This is one of a series of six hearings that we are holding this month in Iowa to investigate rural health care. All six of these hearings will be in various parts of the State, in small rural towns, and in every part of the State.

I am pleased, particularly, that you could join us today, because I believe that all of us will come away with a better understanding of the health care situation in Iowa and in small towns and rural areas.

Obviously, as a subcommittee on rural America, we are principally interested in these hearings about the effect and the trends in rural health care. The Iowa hearings and visits to health clinics—I think all of these hearings are associated with a visit to a health clinic—are part of an ongoing effort of this subcommittee to study the problems of rural America generally; not just in health care, but all across the board, and to try to analyze current efforts to address these problems, and to determine the proper and most effective future Federal role in the area of rural development.

Last February, Senator Leahy of Vermont chaired a rural health hearing for us in Burlington, Vt., and there we learned about the special circumstances of those living in rural New England, and about some innovative and grassroot activities to deliver health care services to the people in Vermont and New England. We learned that attempts to attract health personnel to remote areas are stymied by archaic medicare reimbursement regulations, and we committed ourselves, Senator Leahy and myself, to working to revise these regulations.

As you know, nonphysician health personnel cannot be reimbursed under medicare unless under the direct supervision of a physician. We think that has to be changed, and that's been really our major attempt, and will continue to be, in the next session of the Congress.

We also learned in these first hearings that we held in Vermont that communities need financial assistance in the stages of establishing a primary care clinic, or at least many communities need some, at least minimum, financial assistance—grants or loans. We did successfully amend an amendment which I offered to the health manpower legislation this summer, to do that. Now, we are in Iowa this month to assess the special needs or programs in this area.

Next year, the subcommittee intends to conduct similar investigations in Appalachia and in the southern States, so that it is truly a thorough national investigation of the health care delivery system in rural areas.

Our goal is to return to Washington with very concrete proposals to fulfill the promise of providing adequate health care services to all Americans, regardless of whether they live in the most affluent suburbs, or in the most remote rural communities; however, this objective can never be accomplished without the help of people in rural areas.

Legislators obviously cannot sit in Washington grappling with rural health issues with which we have little or no day-to-day experience. The insulation of many Federal policymakers from practical reality has obviously led to ineffectiveness in several of these programs; and, in turn, American citizens have lost confidence in the ability of the Federal Government to confront major national problems.

Now, I might say that the whole rural health care problem, the whole rural health care situation, I guess, is a better way of saying it, is going to be very much involved in any new national health insurance programs that may come about in future years, and we have to be very concerned that those programs are not simply designed for metropolitan areas, and that we have all of the careful input of people in rural areas, particularly health personnel themselves that have experience here, so that we don't create something that has little or no—or unequal application to people who live in rural areas. Obviously, people who live in rural areas pay taxes like anybody else, on the same basis, and they are entitled to the same kind of medical services to the best of our ability to deliver them.

For this reason, we are here to listen to those of you who have intimate knowledge about the health needs of rural Americans, and are effectively involved in attempting to serve these needs. Our Nation has spent millions of dollars, hundreds of millions of dollars, in the past few years to encourage health professionals to practice in medically underserved areas; and, in frankness, these efforts have not been very successful. Therefore, health personnel are still clustered in urban and suburban areas. Without new Federal initiative, based on our experience in States like this one, the geographic maldistribution is almost certain to continue.

Now, Iowa is no exception to the general picture. The country, as a whole, has 130 general-care physicians per 100,000 people. There's 130 per 100,000. That's the national average. Iowa has only 55. Now, that's less than one general-care practitioner per every 2,000 people. That's a good statistic to remember. We have less than one general-care practitioner for every 2,000 Iowans.

Now, even this understates the problem, for half of the State's physicians are located in just 6 of the 99 counties—half of the physicians in 6 of the 99 counties. To make matters more difficult, 1 of every 3 physicians in our State—1 of every 3—is over the age of 60; so we have some particular problems here in our State.

I don't mean to suggest for a moment that county lines are magic. I think it is just one way of looking at it. In fact, we are probably too geared to the idea of county lines when it comes to health care. It is not the most meaningful kind of analysis, by any means, and I am not suggesting that every county ought to have the same number of doctors, because that would be ridiculous, but it is a way of looking at the problem of maldistribution.

I might say that three counties in central Iowa—since we are meeting here today in central Iowa—have been especially hard-hit by lack of health professionals. The National Health Service Corps, the Federal program which places young doctors in rural areas, has determined that nearby Story and Marshall Counties have critical medical shortages. In Jasper County, to name a third, only 70 percent of the current need for general care physicians is being met, as calculated by the Iowa health manpower plan for 1975. In other words, as calculated here, and you can see, by the way, on the map here, some critical shortages of general care physicians in the State as a whole.

As you can see, this is no time to be complacent about health care services in rural America. It is time to take a hard look at where we have been, where we are at now, and where this Nation ought to be heading in terms of addressing the health needs of its rural citizens; so I look forward with interest to hearing the panels today. We are going to be hearing first from a panel from Madrid, a community which has done some very interesting things; and second a panel from Osceola, so we are going to take about 45 minutes. We are going to have some brief opening statements from each of the panelists here, and then we are going to have—after we have heard the statements, we are going to have some discussion for about 45 minutes, and then we are going to go to the panel from Osceola and do the same thing.

Then, by the way, I think we will have some time for anybody here who may wish to make any comments at all, statements, questions, whatever may come to mind, at the end of the meeting.

Let me say that the first three panelists are Richard Pustka—am I pronouncing that correctly?

Mr. PUSTKA. Yes.

Senator CLARK. Mr. Pustka is a physician's assistant at the Madrid Clinic; Dr. Anderson, John Anderson, a member of a group medical practice in Boone that operates the Madrid Clinic; and Glenn Allen, an attorney in Madrid that has been active in community health affairs.

Gentlemen, you can proceed in any way you think appropriate, and after you have all three spoken, I will have some questions.

**STATEMENT OF JOHN R. ANDERSON, M.D., MADRID CLINIC,
BOONE, IOWA**

Dr. ANDERSON. Family Practice Clinic in Madrid was set up approximately 3 years ago. Madrid had been without a physician for several years. The Boone County Medical Society had attempted, with help from a committee from Madrid, to recruit a physician.

This becomes exceedingly more difficult, as everyone is aware, trying to get physicians to go to small towns in Iowa. An opportunity arose, through one of my partners, who happened to know Mr. Pustka, in the military service. The concept of establishing a physician's assistant, at that particular point in time, was very new to me. This was a concept that I really hadn't quite completely understood. After a great deal of research and soul searching, and after talking with the people of Madrid, we decided to go ahead with this project.

I might say that the people of Madrid have been tremendous in their acceptance of this type of medical care. It does allow them entry into the health delivery system, and entry into the hospital. It gives coverage 24 hours a day, and it is a means of accomplishing our goal.

Physicians in Boone were taxed in that they had all that they could really handle in their offices with the Boone patients. We did not feel that we had the time to come down and even set up a part-time clinic in Madrid. But by utilizing the physician's assistant concept, we are able to allow for some coverage 24 hours a day, and entry into our health care system.

So from our aspect, we have been very pleased, and, as I say, we have been most gratified with the response of the town of Madrid for this type of medical care system. We have had our problems; however, we have had a great deal of help from the Peterson Foundation in Madrid, and from just the townspeople themselves. The problems have all not been insurmountable, and we have been able to cope with them.

Senator CLARK. What is the Peterson Foundation?

Dr. ANDERSON. This is a nonprofit corporation set up in Madrid. I don't know the exact ramifications of it, but I do know that part of its function is to help the medically needy individuals. Mr. Allen could probably tell you more about the foundation.

Senator CLARK. How large is Madrid?

Dr. ANDERSON. Approximately 2,500.

Senator CLARK. I don't want to get into questions, except just for the second phase. Where is your closest physician?

Dr. ANDERSON. The closest physician is one in Slater, and one in Woodward.

Mr. PUSTKA. Huxley.

Senator CLARK. How far are those?

Dr. ANDERSON. Five and ten miles.

Senator CLARK. Anything else at all that you want to say in the opening statement?

Dr. ANDERSON. That's fine.

Senator CLARK. Who would like to go next?

STATEMENT OF RICHARD PUSTKA, PHYSICIAN'S ASSISTANT, MADRID CLINIC, MADRID, IOWA

Mr. PUSTKA. My name is Richard Pustka, and I am a physician's assistant associated with Dr. Anderson and Dr. Rouse. I would initially like to define the word physician's extender. Sometimes we get confused. There are many terms given to the dependent professional and nurse practitioner, medics, physician's assistants. These are all nomenclatures given to the extension of the primary care physician and subcategorized into extension of the specialist. Of course, today—

and we speak from our direct experience—I am an extension to the primary care physician, or the family practitioner, and a brief history—the physician extender concept began in 1965 at Duke University, and currently that gives us 11 years experience with the concept, which is really, in essence, a short period of time.

I think it is very important, at the onset, for not just the public, but our legislature to understand also that as a physician's assistant or extender to the primary care physician, I am not a replacement physician, and this is an important concept, and some confusion does and has existed specifically on this point.

As a physician's extender, a direct extension of the physician, besides the obvious by allowing the patient, in our case a town of 2,500 with no medical facilities previous, to gain entrance into the medical care system of Boone County Hospital and into the system of health care in Iowa, with a county hospital associated with university hospitals in Iowa City, is very very important.

When your child is sick at 2 o'clock in the morning, how do you get in? The system is there. Iowa, I think historically has been very fortunate in having good medical care available to the people of this State, but it does present a problem, and is presenting a problem to some people to get into the system.

As a physician's assistant, in a satellite office, this does allow the people in small towns to do so. At the same time, repeating myself, not as a replacement physician, I am under the direct supervision of the physicians at all times.

There is a point of geographical independence, with Madrid being 14 miles from Boone, and my supervising physicians. We do have telephone and radio communications, both with the physicians and with the hospital. The consultation and supervision by the physicians is not one sided at all. It is a many-faceted thing. Besides telephone and radio communications, I can admit the patient to the direct service of the physician, have the patient seen by the physician at the time, and/or have the patient seen by the physician, say, for instance the next day, or that afternoon in his office, or Madrid, depending on the urgency of the situation.

There are two more issues, I think. One is professional credentials. I think we overrate these sometimes. We do have an American Academy of Physician's Assistants, which does work closely with the American Medical Association on their Committee of Allied Health. It has helped tremendously by giving their full support to the concept, and helping in the organization of training programs of physician extenders in the country. Training programs with emphasis on one-to-one physician training rather than emphasis on credentials is important.

The National Board of Medical Examiners, which is the accepted—I believe accepted Federal agents—for medical registry and they are whom the American Medical Association, and, I believe the American Academy of Osteopathic Physicians, accept as a licensing board for physicians. We do have a national registry for physician's assistants, and are required to take upwards of 100 hours of continuing medical education every 2 years.

We have a national certification examination that is written every 5 years to maintain registration as an extender, so there are a lot of

things being done, and that have been done, that were—although not initially innovated—quite important to this concept of just who is a physician's assistant or nurse practitioner. What does she or he do, and for whom?

I do those things that I believe a physician's assistant or physician's extender should do. There are many things that only a physician should do, and I do not believe a physician's extender should ever be put in the position of being a physician, even however slight. At the same time, by doing the well-baby exam under supervisions, with review by the physician, by giving that emergency care at 2 o'clock in the morning for a heart attack, a car wreck, the airplane crash outside of town, without the physician directly there—this is well documented, in that the care is needed at the time, and it's there, and how do you get it?

I think the problems, as you all know, are just endless, and how do you get physicians in small towns? I don't think physicians are going to small towns; it's just a matter of more physicians leaving than are coming, and I don't think the physician-extender concept is a complete answer, by any means. I personally am not for putting PA's in communities or—

Senator CLARK. PA's, physician's assistants?

Mr. PUSTKA. Physician's assistants or nurse practitioners, replacing physicians in Iowa. That's not the answer. We need more doctors. At the same time, it is proven that this is a workable program to extend medical care to many people. One important point I wanted to make at the end is that reimbursement under title XVIII and XIX, as it is presently written, will abolish and stop the concept of physician's extenders within, I would personally guess, 2 or 3 years.

Senator CLARK. Expand on that. That's one of our major interests there.

Mr. PUSTKA. I want to give you a good example. As of right now, Dr. Anderson and Dr. Rouse, and myself as their assistant, are part of a Social Security Administration study that did make legal reimbursement of a physician for services rendered by the extender, and I believe the Social Security Administration study will last 2 or 4 years—talking to them in recent weeks—but unless the study is a realistic one, and answers questions that really need to be answered—the cost of medical care, is it going to go up using physician extenders? There are a lot of questions that hopefully the study will answer, and if it does answer in the positive way, which I obviously feel it will, and enough legislative support is found, coupled with support from the people, a change in the reimbursement law will be possible should the reimbursement law be changed? Just to use a short example, in Madrid we have a nursing home with a census of 145 residents, and in this home—

Senator CLARK. One hundred what?

Mr. PUSTKA. Residents. In this nursing home in Madrid, to receive medical care prior to Drs. Anderson and Rouse opening their offices and putting the physician's extender, myself, in it, the medical care, or the cost of medicine, or a typical, problem routing, or entry into the medical service, would be: (1) a nurse would make a decision—and a very competent one as a professional—that the patient needed hospital care, or needed to see a doctor now, (2) so she would find the

doctor on the telephone and convince him that the patient did in fact need to be seen.

This being accomplished, (3) an ambulance would be dispatched the 14 miles to Madrid, pick up the patient, bring the patient to the Boone County Hospital outpatient emergency room, where (4) the physician would examine the patient and render the medical service, treatment, diagnosis, et cetera, either admit the patient for care, or write an order and put him in the ambulance and send him back home either at that time, or after the hospital stay. The cost of this, you know, and I would guess is around \$60 to \$100.

For instance, using an example of a case of pneumonia—and we want to talk about money and cost of care—say the patient—I will feel free to use my own example here—has pneumonia. The nurse calls me. I am in Madrid. I go to the home, and examine the patient. Now, depending on the consultation I have with the physician, and physical findings, and set criteria for diagnosis and treatment, given the confines of the extender organization, I will either talk to the doctor about my findings, and recommended treatment, and conferring with him either on the telephone or radio, I may admit the patient to the hospital, with the ambulance, and the whole bit. The patient may need that. It's the physician's decision at the time.

Say in this example, the patient has pneumonia, with no complications, and orders are written. The patient is treated at the home, and in the story she does well. The cost there is \$10 as opposed to the \$60 to \$100 emergency outpatient hospital charges and ambulance charges.

Senator CLARK. Let me bring you back to something that I thought you said; and, again, I don't want to get into the question period, but just to finish this off before we go on to the other witness, you said that you thought in 3 years, if these titles were not changed for reimbursement, that there wouldn't be any physician's extenders. Expand on why you think that.

Mr. PUSTKA. Only because of the Social Security Administration's study, and it was essentially laid wide open to all physicians and extenders in this country to the best of my understanding. The physician will not be reimbursed for the services rendered by the extender under his supervision.

Now, this would mean that unless the medical services rendered with the physician in physical attendance, and this is, by the way, just an interpretation of the legal staff of HEW—which they contradict themselves by verbally, No. 1, speaking to the American Academy of Physician's Assistants, and also by their support and complete funding of PA programs. They have physician's extenders as employees in the health service, but—

Senator CLARK. In other words, you think this could be changed by administrative interpretation, if necessary, rather than by law?

Mr. PUSTKA. If Dr. Anderson and Dr. Rouse will not be paid for the services rendered by myself for title XVIII and XIX, I don't see how they could keep the office open in Madrid.

Dr. ANDERSON. It would financially be impossible without title XVIII and title XIX reimbursement.

Mr. PUSTKA. The extender would have to work with the physician in the office, what we are doing then is doing away with the concept of physician extenders in satellite rural offices.

The physician's extenders would have to move to the area of the physicians; and, in a sense, work out of the doctor's office.

Senator CLARK. How are you being reimbursed now?

Mr. PUSTKA. We are being reimbursed as part of the Social Security Administration project. We are allowed to be reimbursed through the carrier, third-party carrier, which, for Iowa, is Blue Cross-Blue Shield.

Senator CLARK. How are the other 50 physician's extenders being financed now in the State?

Mr. PUSTKA. I am sure that the vast majority, if not every physician's extender, is included in the study.

Senator CLARK. OK.

Dr. ANDERSON. A majority of the physician extenders in the State are probably working directly in a physician's office, or they will move to a town, and the doctor will be there for certain hours. The clinic is open for certain hours, and the direct supervision is, as I say, being accomplished. We are kind of unique in this 14-mile separation here. There are six satellite offices in Iowa.

Senator CLARK. Let's hear next from Glenn Allen, an attorney in Madrid.

STATEMENT OF GLENN E. ALLEN, ATTORNEY, MADRID, IOWA

Mr. ALLEN. Thank you, Senator. First, I want to say I applaud your definition of the problem, because I know you certainly have approached it and come to the same conclusions that I have long since, that there are areas in Iowa which are underserved, because they are separated from a metropolitan area, or from an area where there's a hospital or a group of doctors.

Truly, we cannot economically attract doctors, and the Government hasn't had great success with moving doctors to these small areas. Probably if they were moved, they would be underemployed, and a resulting waste of their talents.

I think we people in Madrid have achieved a unique solution to this problem, and to those in the audience, I would highly recommend this solution, and I would applaud your efforts to continue it. What we need is more people to deliver the services. The nature of the services delivered is well within the range of ability of extenders. Let me use the word physician's assistant. I agree that physician's assistants must be under the supervision of well-qualified people and regulated.

In order for the program to continue, and for medical services to be delivered to the people at a reasonable price, we must increase the number of physician's assistants, and I think permit them to go to satellite offices, as has been done in Madrid.

I would hope you would pursue it, as provided in your amendment you have presented, or are considering an amendment. I would rather have it done that way, than by regulation, to tell the truth.

Senator CLARK. It could always be changed by regulation.

Mr. ALLEN. Right, Senator, this conclusion was reached several years ago when the Internal Revenue Service went under the deductibility of medical costs. At first, the medical costs to be deductible must have been performed by a doctor or a nurse, et cetera, and then

we began to claim that they were the kind of services that should be judged, rather than the degree of the delivering person, and they did come to this conclusion, and now if we have somebody employed as a nurse in a home for an aged person, those medical costs are medical care.

I have had quite a little experience with this, because in the service, I was a chief pharmacist's mate, and we delivered medical service to people. They didn't inquire about the degree that we held, but asked were the services adequate. This is a tremendous benefit to the people, for the reason that there are many, including those in the home that Mr. Pustka referred to, and also the other people in the community, those that have small children, if they must take their child to a doctor in a far community, this takes time and effort, and is expensive.

These services can be and are being delivered in Madrid by the physician's assistant at a cheaper cost, both at the doctor's office, or at the clinic, and to the individual in his saving of time. This is generally true throughout the area.

We are unique in Madrid, and maybe I am so enthusiastic about this, because of the nature of our physician's assistant. We have a very good one, and the doctors, I think in this case, it happens to be medical doctors, but I think they must be closely supervised, and I think the supervising doctors in our situation have done a wonderful job. Without their cooperation, we could not have achieved the good results that we have, but it isn't beyond the ability of any small community to achieve this.

I don't see many people from the local community of Madrid here, but for you people who are suffering from this problem. Only this morning, and I didn't do this on account of this hearing, but I set up my annual physical. Normally I go to Des Moines for this at a cost of about \$80. This morning—I had previously arranged this—I arrived at the office. The nurse does the medical workup, and I'll get my physical, which is a perfectly adequate physical, at a considerable less cost, and a considerable saving in time.

Senator, actually I have saved enough time to come down here to appear at this hearing, because I could have this problem handled locally. Now, if you find something, I will be referred to adequate medical consultants, and I think you will all find this true.

Now, I do want to touch on one other point, Senator, and that is the matter of grants and loans. While our services are very adequate, we do need a more adequate clinic, and we have not been able to generate the funds locally.

Now, we have had several conferences about this—how we would generate funds so that the physician's assistant would have a better facility to do his work. I don't say it is beyond our ability, but I would applaud your work in an effort to get grants and loans.

I do feel the community has to show good faith in this. We have to put something in the pot, so to speak. I don't think we should expect the Federal Government to come in here and say, "Here's a clinic." I think we have to lift ourselves up by the bootstraps, so perhaps you are talking about low-interest loans, a la senior citizens' housing situation, but I want to say again I do applaud your study of the problem, and I think you have defined it well. I think you are on the right track.

May I further say you have rather confined your investigation and hearings to rural areas. I am not certain at all, but what this solution may very well apply as legitimately to urban areas, as it does to the rural areas. Thank you.

Senator CLARK. Thank you very much. I think that's well worth saying. It happens that I am chairman of the Rural Development Subcommittee, so I am holding hearings there, because I have jurisdiction there, but I would think, insofar as things can legitimately be done by health extenders of various kinds, that that makes some sense, not just in rural areas. That's something we can talk about.

I'm going to have to take about a 5- or 6-minute break, because of some other requirements that I have got, but we will come back to the hearing in about 5 or 6 minutes, and I want to continue.

There are a great number of questions that I want to talk to you about, in the sense of Madrid, particularly—it's a unique situation, how you are trying to solve that—and then more generally about the application of these principles in Madrid to the national situation; that is, what kind of Federal legislation, national legislation would be required.

Let me just say, before I forget it, Mr. Allen, we did pass legislation, as I said, an amendment, which would give loans of up to \$50,000 to set up a practice; that is, constructions, renovation, equipment, and so forth. This was just passed into law. In fact, the amendment that was passed in the Senate had a small grant and loan program.

They dropped the grant in the House version, and in the conference it got dropped, so what we have is up to a \$50,000 loan, as you say, not unlike the senior citizen housing loan program.

I have to step out for just 5 or 6 minutes, and then we will be right back to the hearing.

[A short recess was taken.]

Senator CLARK. The hearing will please come to order. Let me say that I have been looking at some statistics. There may be some more recent ones—I hope so—but I will read right off the HEW charts, so that I am very accurate for the record here. The number of active non-Federal physicians and population physician ratio and percent increase—this is an important point—and percent increase in physician by geographic division and State in the United States between 1968 and 1973. These are the latest figures we could get. In other words, how much in Iowa, as compared to the rest of the Nation—what kind of percent increase in physicians have we had.

Unfortunately, we are 49 among the 50 States. This is increased number of physicians in the State. We have had, in that 5-year period, a 6.3 percent increase. The national average is 16.7 percent, so that we are well below half of the national average in terms of increasing physicians into the State.

There is one State lower, and interesting enough, it is South Dakota, and it is much lower, 1.4 percent. We are second lowest, 6.3 percent, and then they are all the way up to New Hampshire, which must be the climate, 26 percent, so that I noticed in passing that Mr. Pustka said that he felt that the final answer was not simply physician's assistants, but doctors themselves, and if these figures are still accurate over the last 2½ years, these trends, it means that we have a real problem in terms of physicians, as well.

Perhaps somebody here has more up-to-date statistics than that. Identify your name for the record here.

STATEMENT OF DR. J. LEONARD AZNEER, COLLEGE OF
OSTEOPATHIC MEDICINE AND SURGEY, DES MOINES, IOWA

Dr. AZNEER. I am Dr. J. Leonard Azneer. I have served with a couple committees for the office of program and planning. These are some interesting things I have heard. Using the figures that you used, in this State at a recent meeting, Dr. Seebohm of the university and I had to sit and suggest that that data base would suggest that we have an adequate number of practitioners in this State, which is obviously not true. One of the big problems is that most of the grants given to the planet organization with which to develop the data on which, or from which you can come to conclusive evidence that does not permit the acquisition or gathering of new and meaningful data.

To illustrate that point, Senator, you pointed out that there are probably 30 percent of the physicians that are going to retire, or are in the retirement age in the active ranks today, is that correct?

Senator CLARK. Yes.

Dr. AZNEER. However, no one has asked or defined accurately what constitutes a physician in Iowa who is practicing, and cursory examination shows that in part time—farming part of the time, and they may be practicing as little as 2 months a year, but they are carried as active physicians. This creates a situation to a degree where probably a thousand doctors would not solve that.

Senator CLARK. Can you throw any light on the issue that I brought up; namely, that the number of physicians coming into the State is second lowest in the country. Again, you say it is a matter of definition as to what a physician is.

Dr. AZNEER. Well, when you say, "Can you throw any light on the situation?" it's a very complex situation. It's a question of attracting people by showing them there are good facilities to work in, and indeed breaking down the parochialism that exists in certain areas between physicians.

The other part that I should like to suggest is that you will never succeed in bringing one doctor into a rural area. It's a matter of sudden death. When I hear there's a physician's assistant in Madrid, Iowa, I'm delighted; however, Madrid is large enough to support more than one physician's assistant. It's large enough to support a doctor.

Senator CLARK. We will want to get into that in the process of the discussion, but I wanted to just mention the factor of the additional physician, but we will be taking comments from the floor a little later.

Dr. ANDERSON. Regardless of that figure, I think probably in Iowa today that figure would be elevated somewhat. I think you will find that most of your family practitioners are going to stay in the State where they took their training.

Iowa recently has opened up many family practice residencies within the State, and these graduates are now staying within our State, and I think from 1973 on, figures would be a bit higher.

Senator CLARK. Good. We are going to be looking at some figures in Mechanicsville, and I think we will be going to Red Oak, so we will hope to get a broader view of that kind of thing as we go along.

Now, I wanted to ask; and, by the way, as you know, we are going to be going over to Madrid following this to at least get a look at your facility and what is happening over there, and we will visit with you on the spot.

Mr. Pustka, I am wondering, just basically in your own case, what your own qualifications are, in terms of this position. How did you prepare yourself? Give us a little background about yourself, and how you got into this, and why, how well qualified you are.

Mr. PUSTKA. To answer the question direct and simply, how well qualified I am, with all and any credentials I do have allowing me to be a physician's assistant, I know much less now about medicine than I ever did when I finished any of my training programs. After 3 years in Madrid, I find myself knowing less and less and less.

I was in the Navy for 4 years, a military corpsman on independent duty 2½ years of that time, 4 years of college, and a 2-year physician's assistant program at the U.S. Public Health Hospital in Staten Island, New York; from there, successfully writing the National Board of Medical Examiners certification examination, the national certification examination, and the continuing medical education required by the Academy of Physician's Assistants to maintain that certification, and continuing, ongoing forever, supervision by the physicians.

Senator CLARK. All right. Now, I am just curious about what kind of things you do on a day-to-day basis. If somebody walks in the door, what's your value? Take last week, or the week before, whatever. Just give us some example. Did somebody come in and say, "I would like to have my blood pressure taken?" Do you take that? What kind of things do you do?

Mr. PUSTKA. Being the only health provider in the town of Madrid, I do all of that which is within the confines of family practice that I am allowed to do, under supervision from the doctors, and from training in the overriding precedent that I do not consider myself a physician.

Senator CLARK. What does that include? What can you do? Can you give us some examples, thinking back over yesterday, or last week, the week before?

Mr. PUSTKA. I will take yesterday. I had a house call at 6:30 yesterday morning to an elderly couple. An elderly lady was having trouble breathing, and I made a presumptual diagnosis of congestive heart failure, and had her transferred, and it was indeed that, and from there I went to an auto accident right outside my door on the highway, and had a lady again transferred to the Boone County Hospital by ambulance.

I don't know if she had a stroke or heart attack, or what. She had a lapse of consciousness prior to losing control of her motor vehicle, with her husband in it.

From there I went to the Eastern Star Masonic Nursing Home in Boone, and saw four patients for routine health maintenance, checking blood pressure, checking blood sugar and insulin requirements, and recertified three or four of the residents in the nursing home.

From there I went to the physician's office and saw patients with him, Dr. Murphy, for 2 hours, and consulted in a teaching process, ongoing weekly teaching process that we do have. From there I had lunch with the physician and went over some internal business problems over lunch with him.

I returned to Madrid about 2 o'clock, and I think I saw about 12, 14 or 15 people yesterday afternoon, including young children; a couple kids with earaches; two families, with a total of 14 kids in

both families, for routine immunizations—not routine, they were delinquent, and had never received any immunizations, oral polio, et cetera.

Senator CLARK. That's good. That's the kind of thing I wondered about. In regard to those people, as best you can remember them, what do you think they would have done—what difference would it have made if you wouldn't have been there?

Mr. PUSTKA. A lot of difference; but, in reality, probably none.

Senator CLARK. I wouldn't be so modest. Look at it very objectively. You did provide some care.

Mr. PUSTKA. The residents in the nursing home, with the amount of physicians we have in Boone, would not have been seen in the home yesterday, except for maybe one of the ladies. No care would have been given to the lady with congestive heart failure initiated at the time. The ambulance transport time, under ideal conditions, is 40 minutes. That treatment that I gave to the lady with the heart failure could have been initiated probably with no more sequelae than she will have anyway.

Senator CLARK. Except she might not have had it so soon.

Mr. PUSTKA. Forty minutes sooner.

Senator CLARK. That could be crucial.

Mr. PUSTKA. Yes; but you can't "could be." Now, the airplane accident a couple months ago, that lady documentedly probably would not have survived or been around today unless a physician's extender, and able to do what I can do under life-threatening situations, was there.

Senator CLARK. What about—that's a good example. What about the children that came in in the afternoon; what would they have done about the immunizations?

Mr. PUSTKA. They could have driven the 14 miles to Boone, the 5 miles to Slater or Huxley, if they could have gotten in. The oldest child in the one family is 16 years old, and they had never received any immunizations.

Senator CLARK. Do you think they would have done that? I think it's anybody's guess.

Mr. PUSTKA. The mother came in with one of the younger children with a laceration late at night. She called me at home. I met them at the office, repaired the laceration several weeks ago, and I took the sutures out Friday of last week, and I asked the mom—working for family practitioners and taking data basis with the concept of family medicine—instead of just taking care of the cut: "What shots have they received? Have they ever been in the hospital? Do you have any medical problems?" They had never received any immunizations, and I frankly told the mother that I strongly felt, unless she could give proper immunizations to these children, which I feel is very, very important, please do not call for me for any care; that I did not wish to be responsible for the health care of their family if she could not take the initiative to be responsible for the health care of her own children.

Senator CLARK. That's why she brought them in. Let me ask you now. I guess you will have to give me brief answers, but some things that we would like to have on the record, for one physician's assistant feeling about this kind of thing, how important is it that you live in the community that you serve?

Mr. PUSTKA. Important.

Senator CLARK. Why is that?

Dr. ANDERSON. You can't always get sick from 8 to 5.

Senator CLARK. That's about it?

Mr. ALLEN. I would like to answer that question. I think it's very important that we all feel much more comfortable, because when we have a problem, we can get into the office. We can get the care, and if it requires more than his ability, we are in the medical system, and we are cared for, and I think in the case of a heart condition, I think it's imperative that they be treated at once.

Senator CLARK. And emergency care of other kinds?

Mr. ALLEN. Yes.

Senator CLARK. What about this—how about when you went into Madrid. Did people like this idea? Were they reluctant about it? How did you get accepted? What was the community's reaction?

Mr. PUSTKA. It probably took a while. They hadn't had anyone in the town for a couple of years, I guess, and I spent a little over a month with the doctors in Boone on a 1-to-1 basis, teaching them what a physician's assistant was first, before we came to Madrid, and—I don't know. I started to work the full day the first day, and have been seeing sick people ever since.

Senator CLARK. They started coming in right away, so it wasn't a question of having to wait for a year?

Mr. PUSTKA. Madrid has three doctors and a physician's assistant 24 hours a day. That's important. If I'm not at home, and there is an emergency call from anyone, there is an "if no answer" number, which is the emergency physician in Boone. Madrid does have two full-time—access to two physicians, the physician's assistant, and the emergency medical care system of the county, so they don't just have a PA living there.

Senator CLARK. I know this is hard to summarize briefly and quickly, but what's the nature and importance of the relationship between yourself and the physicians?

Mr. PUSTKA. All important. I do not and did not look at what salary was offered, what fringe benefits were offered, what the working hours were going to be. I looked at two things, and two things only, my personal conviction and motivations that bring me to smalltown living, and bringing my family including two children, with me, and the relationship with the doctors. What type of relationship am I going to have with the physician? The relationship between the physicians and physician's extender dictates the quality of medical care rendered, and that's the most important thing.

Senator CLARK. How about you, Dr. Anderson, from your point of view, what is that relationship? How would you explain it, just briefly, in terms of your relationship to the physician's assistant? How tightly do you watch that work? What kind of relationship is it?

Dr. ANDERSON. Well, it's an ever-changing one, of course. When I first thought of putting a physician's assistant down in Madrid, I was scared to death. This was until Rick and I did have time to work together, and I could learn what his qualifications were, and he could learn what I expected of him, how I wanted to treat patients, set up establishing roles of what I expected of Rick, what he could do on his own with my guidelines, what he could not do, when he should

call me; and, of course, as we have worked together, this has been a changing role, because he has become more proficient.

Senator CLARK. Does it work?

Dr. ANDERSON. Yes; it works.

Senator CLARK. What are the advantages of it, as you see it from your vantage point, for the people of Madrid, I am saying?

Dr. ANDERSON. Well, we have a situation where Boone has physicians in numbers that they were full taking care of Boone people. Madrid was sitting there without any medical coverage. We had a hospital located in Boone, which is a county hospital, which could utilize the business from Madrid, but there was no way for the people of Madrid to get entry into the system. There wasn't enough time slots in our appointment schedules to see all these people. By putting Rick down here, we allowed this entry into the system. So it was beneficial to the people of Madrid, and it was beneficial to the Boone County Hospital.

Mr. PUSTKA. And it cost you more work.

Senator CLARK. Tell me this, Dr. Anderson, some people say that nurse-practitioners and physician's assistants, and so forth, should be covered for their services under medicare and medicaid. What's your judgment?

Dr. ANDERSON. I definitely feel they should. I think, as was stated earlier, if we had no payment at all for Rick's services for title XVIII or title XIX, economically it would not be feasible to open up the doors, and it would be an impossibility.

Senator CLARK. So this whole process is not going to work if we don't make that change, in your judgment?

Dr. ANDERSON. I think going one step further, Senator, I think part of this problem of physician distribution is on the same basis. Our medicare-medicoid reimbursement policies to physicians encourage physicians to go to the metropolitan area.

Senator CLARK. Why is that? What reasons?

Dr. ANDERSON. Well, they have areas of the State regionalized, so that if you are living in the metropolitan area, for the same service you might get \$10, and living in a little town like Madrid, maybe you are going to get \$6 for the same procedure.

Senator CLARK. I wanted to ask Mr. Allen, many small towns can't attract doctors to practice there. I know there is no simple answer to that question, but you have obviously been interested in that problem for a long time, and been involved in it. Why can't Madrid get a doctor?

Mr. ALLEN. Well, principally because it is uneconomical for the doctor to be attracted to a small town. The same thing with a lawyer. When I went to Madrid, I was putting a lid on what I was going to earn, and the same thing is true of a doctor. Now, you have to balance that against country living and good people, and sometimes the economic end of it loses.

I want to reinforce what Dr. Anderson said. We have a very happy situation there now. Without the medical payments under XIX—XVIII and XIX, this thing is gone tomorrow, because it has not been an economic advantage for the doctors in Boone to handle it. They could have gone ahead and had no—they could have ignored our

problem, and they would have been just as well off, as well as they are now. We have suffered—we have gained a great advantage in their kindness, and it has helped our community, but without title XVIII and XIX, the thing is gone tommorrow, and that is a must.

Senator CLARK. Good. Well, I appreciate having that testimony. Let me ask just beyond that—why were you successful in Madrid in getting this kind of arrangement? A lot of other communities haven't done anything. Why were you successful?

Mr. ALLEN. I think I will let Merrill Sundberg answer that question, because he is trustee of the Peterson Foundation, and he is also president of the Iowa Lutheran Home for the Aged—it's not called that any more, but that's what it was—and Merrill could tell you—Merrill, would you tell the Senator the answer for that question?

Senator CLARK. Why did you get a doctor in Madrid? Why were you successful?

STATEMENT OF MERRILL SUNDBERG, IOWA LUTHERAN HOME, MADRID, IOWA

Mr. SUNDBERG. We tried very hard. There was a committee of us that tried very hard to get a physician, and Dr. Wicks, who was formerly a partner of Dr. Anderson, and an old friend of mine. I consulted with Dr. Wicks on getting a physician to come to Madrid, and he said, "Well, we have this new concept of physician's assistant," and he said, "Do you think you could sell that to the people of Madrid?" I said, "If you are behind it, and your men are behind it, your staff there, your partners, we can sell it."

This Adolph Peterson Foundation, of which I am chairman, is a charitable foundation we have in the community, and we use it for educational purposes and medical purposes, we bought a building from a former doctor, the office which is now being used, and we rent that to the doctors in Boone, in order that they could have a place to come.

Might I say, too, that as chairman of the Lutheran Home—I don't know if you are familiar with this—but this is a 150-bed nursing home that is owned by the Lutheran Church in the State of Iowa. It has presently from 135 to 145 residents, and I talked to the staff over there, the administration, and to the nursing staff, and they feel that the coverage we get from Rick is better than it was when we had an M.D. in Madrid.

We are very concerned about this payment on title XIX, because many of the calls over to the Lutheran Home are—might be called simple calls that Rick handles very well himself, but we realize that if we can't keep him in Madrid, our home is going to have to be forced closed, and we have a staff of about 70 people, with about a half a million dollar payroll, and it would be a great hardship in the community.

I might say, in closing, that Rick is very modest. The community is very enthused about him, and the stories going around about the things he's done medically in the community are beyond imagination. Everyone is enthused about him.

Senator CLARK. Thank you very much. I think that's a good note on which to end this panel. It's been very interesting, and you are to

be congratulated, all of you, on the progress that you made. It's a good example for the rest of the country to look at and study.

We would like to have the witnesses now from Osceola come up, Mrs. Diehl, Dr. Kimball, and Beth Brown.

Let's go ahead. We are looking, obviously, at another community, Osceola, which, I think, is in Clarke County. I ought to be able to remember that. I think you can go in any way that you think is most appropriate.

I think you have down Mrs. Diehl, Dr. Kimball, and Beth Brown, but if there is a more sensible order, we can go in any order. It doesn't matter at all. We want to hear all three of you talk at first, and then we will go to questions.

STATEMENT OF JAMES D. KIMBALL, M.D., OSCEOLA CLINIC, OSCEOLA, IOWA

Dr. KIMBALL. I would like to keep it—what I have to say very simple. It seems to me that in my thinking of it, there are about three areas that people get concerned about in rural health and urban care, health delivery. They want it to be readily available, and they want it to be at a reasonable cost, and they want it to be of quality. I think that nobody will argue with that, and the thing that we are really talking about today is availability, and that has to be based kind of realistically, and I think it is based to a great deal on the number of doctors available, and Dr. Anderson touched on that a little bit, with the increased number of family practice residents in the State.

I think you are going to see an increase in the number of primary care physicians in the State.

Senator CLARK. You think there is a trend toward an increase?

Dr. KIMBALL. It takes a while for the program to get geared up, and get people in it, and start producing people. I think there are about 50 people in training now in the State that weren't before. There were no programs for county practitioners before, and they had to take their training elsewhere and come back to the State. Now they can take their training in the State. That's a Federal-State program. We are keeping up. I think that distribution, as you mentioned, is quite important.

I notice that we are not considered to be critically short; however, we have probably records of 10,000 people in our clinics. We are the only physicians who are busy and working in Osceola, and the county has 7,000, so that the ratio of physicians to people is rather bad.

I think it's important that we not lose track of what attracts doctors to a community. I think hospitals attract doctors to communities. They have to have the tools to work with, and it's nice to think of doctors going to homes to care for people in their homes, but that's an inefficient means of delivery of care, and when you get inefficient, you start getting more expensive.

Some of our smaller hospitals are in trouble. We have had people who have made statements that the small hospital is on the way out, and it is going to disappear, and I think that that's a sad state, and I would hope that we would work to equalize the payments to the smaller hospitals, so that they—

Senator CLARK. You think it's the same problem that Dr. Anderson was talking about, in terms of payments, the size of payment under medicare-medicaid?

Dr. KIMBALL. I fully agree with his statement about M.D.'s. I think that you have to make it financially attractive for the physician to come to a small area. It's a nice place to live, but it grates a little bit when the guy who lives in Des Moines is making more money, and works fewer hours, so why not go to the "land of milk and honey."

We have kicked around the idea of a satellite clinic. We really don't have a town in our area big enough for one. We have several little towns that would like to have a doctor, and I fully agree that you are probably not going to get a doctor. You have to have some way that the doctor can get away, and if you want 24-hour coverage, you have to have somebody else there, too. I think the biggest problem for people in the rural area is transportation, and I think that their availability of medical care is directly related to their ability to be transported to whatever service or facility that they need.

Senator CLARK. Good point.

Dr. KIMBALL. That is being met, to some degree, in south central Iowa, with a program we have, and we call it a trolley system. They have vans that pick up people and take them around to grocery stores, shopping centers, and physicians. That's all I have.

Senator CLARK. Very good. OK. Who is going next?

STATEMENT OF ANNABELLE DIEHL, FAMILY NURSE PRACTITIONER, OSCEOLA CLINIC, OSCEOLA, IOWA

Mrs. DIEHL. I am Ann Diehl, and my official title is family nurse practitioner. I am also a physician's extender, as explained before—the broad term we covered. A little bit about my background, since you brought that up earlier: I am a rural Iowan, in the beginning. I am not going to say for how many years. I have lived outside of rural Iowa for about 6 years of my life, so you can probably figure out how many years that is.

I was a registered nurse, to begin with—had been for about 18 years, and I became involved in the pilot project cosponsored by the Iowa Hospital Association and the Iowa Medical Society 2 years ago, to train and place some nurse practitioners in strategic sites in Iowa to see if this concept would work.

At the time, I didn't realize the similarity to physician's assistants, and it's really duplication, except for our background, probably.

I completed a 1-year training course at the University of North Dakota. Part of this included on-the-job training, preceptorship in Dr. Kimball's clinic, so we were back and forth between classes in North Dakota, and on-the-job training in our clinic in Osceola. I have been practicing as a nurse practitioner with Dr. Kimball now for a year in Osceola.

Some of the drawbacks—I usually start my day between 8:30 and 9 o'clock at the local hospital, county hospital. Sometimes I make rounds with Dr. Kimball. If he is going to be gone, and wants me to carry information over to the doctor that is going to be seeing the patients the next day, I will go around with him and check on things.

I perform inhospital physical examinations, and I record them for the hospital records. I have certain patients that I see at the hospital

who have already been examined by one of our physicians and have been deemed to need certain types of treatment.

For instance, there is one lady that receives a drug for cancer that has to be given intravenously. This treatment program had already been established. I see her at the hospital, simply for her convenience. It is easier for her family to bring her to the hospital. It is easier for our clinic to take care of her there as an outpatient in our clinic.

That kind of situation doesn't come up too often, but I review her lab work. If there is any change in the lab work, then I will notify the doctor before she gets the medication.

Senator CLARK. So you provide any medical service that the doctor—that is not necessary for him to provide directly? Is that a fair way of saying it?

Mrs. DIEHL. I think so. I don't initiate any new treatment on anyone.

Senator CLARK. Dr. Kimball, you are in Osceola?

Dr. KIMBALL. Yes.

Senator CLARK. Unlike the Madrid situation. How many doctors are there?

Dr. KIMBALL. There are three, and we all work together in a group, and she works with the three of us. We looked at the satellite situation. Part of the program that she was in called for a satellite to be developed, and we looked at the small towns around us to think about setting up a satellite there, and the reason we did not is because it was going to cost us somewhere in the neighborhood of \$80,000, and that was a key issue, I thought, and the other thing that we ran into were a number of questions concerning recordkeeping, availability of pharmacy, and again transportation.

If people are going to get into their car and travel perhaps 2 or 3 miles to a clinic in Murray, which is 10 miles away from Osceola, does it really take them that much more time to get to Osceola, and if you take a doctor out of the Osceola clinic and put him in the Murray clinic 1 or 2 days a week, does that satisfy anything except the travel time?

Senator CLARK. Well, I don't want to get into a lot of questions, because I want to hear from Beth. Had this amendment been in effect that we just passed, where you could borrow up to \$50,000 low interest? Would that have made any significant difference in your case?

Dr. KIMBALL. I don't think so.

Senator CLARK. Well, Ann, you have been doing this about a year?

Mrs. DIEHL. Yes.

Senator CLARK. How do you like it?

Mrs. DIEHL. I love it.

Senator CLARK. Are you able to do more of a substantive nature in the health field than you would in your other—in your previous job?

Mrs. DIEHL. My previous job was the director of nursing at the hospital, and unless you enjoy paper work and trying to get other people to do things the way things ought to be done—I had a very good job, salarywise, hourwise, and conditionwise, but I wasn't taking care of people. I was taking care of schedules and offices, so I like this a lot better.

Senator CLARK. Now, let's go to Beth. You have been active in health affairs, generally, in Osceola. What do you think about this arrangement? What can you tell us?

STATEMENT OF BETH BROWN, OSCEOLA, IOWA

Mrs. BROWN. Well, I have kind of a hard act to follow, attorney Allen is very eloquent, and I am not.

Senator CLARK. I have the same problem, so don't feel bad.

Mrs. BROWN. I think Ann is doing a terrific job. First of all, I was not aware that this hearing was directed specifically to the physician's assistant or family nurse practitioner, or the extender, so I looked into other things.

Senator CLARK. That's fine. We are open to other things. Go right ahead and say anything you'd like.

Mrs. BROWN. You are going to be sorry. We have quite a few children in our family, and I feel very confident when any one of them sees Ann. I know that if she feels they should see a doctor, she will not try to pull rank and play the doctor role. I personally would feel very happy with the situation we have in Clarke County. We have three fine physicians who, by the way, are quite a ways under 65. Now, how we looked on that—Ann is quite a way under 65, so we don't fall under this stereotype of over-65 people.

I think she has a real purpose, particularly when it comes to perhaps the older patient. This could be such a broad thing, I would think, that she could cover to alleviate the doctor of problems.

Planned parenthood is a very—it's a necessary thing, and it's going to have to come about, and perhaps this is something Ann could help set up and cover. We have too many unwanted pregnancies in our community.

Transportation, which Dr. Kimball mentioned, we had not discussed this previously. This is one of the things I had written down. There seems to be a real cry for transportation for the elderly. Now, I think this can be more of a people-to-people sort of thing, where people are helping people. All they have to do is let someone know that they need transportation to a clinic, rather than sitting home and not getting the proper care and complaining about it, but it is a big problem to the older person, and I am certain that they are proud and hate to bother people.

I hear those words a great deal, "We don't want to bother you." I don't know what else you want me to cover, Senator.

Senator CLARK. That's the kind of thing that I wanted, by way of introduction.

Mrs. BROWN. I do know that in talking to people in Murray and Woodburn, if you know where these areas are in connection to Osceola—and Weldon—the Clarke County Clinic covers a large area, even down into Missouri, and so does the hospital—one of the biggest concerns of the people in the area is the fact that we don't have a surgeon right now. We did have, but we don't now, due to death. We don't have a surgeon. They want a surgeon. They are terrified of losing their hospital. They think it's necessary to have a surgeon.

Senator CLARK. How large is the hospital?

Dr. KIMBALL. Sixty-eight beds.

Senator CLARK. You have three physicians in Clarke County, all of you together in Osceola?

Dr. KIMBALL. That's correct.

Senator CLARK. Clarke County is 7,000?

Dr. KIMBALL. Yes.

Senator CLARK. Now, do you assume that you provide virtually all of the health care that physicians provide in Clarke County?

Dr. KIMBALL. I would say most of it. There is a large group of people that come from Lucas County, which is east of us. We get a number of people who come north of us from Warren County, because Warren County has no hospital.

Senator CLARK. How about Union County?

Dr. KIMBALL. Union County—the nearest doctor is 30 miles away from us in Creston, so there is an overlapping there. Some of the people from western Clarke County go to Creston, and some of the people from eastern Union County come to see us.

Senator CLARK. So that the chances are that although some of your people may go out of the county, probably at least as many come in?

Dr. KIMBALL. Well, we have records on at least 10,000 people.

Senator CLARK. That's what I was wondering about. So you serve probably on a regular basis 6,000 or 7,000 as the primary physician for those people, and up to 10,000, to one extent or another?

Dr. KIMBALL. Yes.

Senator CLARK. Now, I wanted to ask you particularly, Dr. Kimball, what does having a nurse practitioner or extender—what does that really do for you that you couldn't otherwise do? Suppose that Ann didn't exist, what does she do, from your point of view, that wouldn't otherwise be done?

Dr. KIMBALL. I think the thing she does for us is she really extends us. Instead of seeing perhaps 30 to 40 people a day, we are able to see 50 or 60 with ease. She can see people and be screening them, and asking them pertinent questions about what is happening, and if there is a question about them, it takes me just a few minutes to take care of the problem, where I would have to do the whole thing myself, so that she is seeing a patient while I am seeing a patient.

Senator CLARK. Just extends you a good deal farther. Now, what kind of ratio makes sense? Could you use another extender, or is that about right, to have one extender for three physicians? Is that a reasonable kind of ratio?

Dr. KIMBALL. I really don't have any experience with that.

Senator CLARK. It's hard to tell, but you are able to see a lot more people now than you did before.

Dr. KIMBALL. I think we see them better, because we can spend more time with them. I have probably the same number of people who come to the clinic in a day, but I can see the ones that I am seeing longer than I was doing before, so I feel I am probably seeing them more completely, and treating them better.

Senator CLARK. Now, I wanted to ask Ann, do you think that the use of a nurse practitioner is of any special value, as far as rural health care delivery is concerned? Now, we are interested in health care all over, but we are particularly interested in the rural aspects of it in these hearings. Do you see any difference, in terms of a rural area, or if you were in Des Moines, would you be providing exactly the same

kind of service? Is there anything uniquely rural about what you are doing?

Mrs. DIEHL. It's a little hard, because I haven't had city experience, but I would imagine that—well, I am in family practice, and I don't think many extenders in the city are as caught up in family practice as they are in specialities, so—yes, in a rural area, I think the difference would be that I am more involved in the community.

In the city, I would be a person to come to that people might not know otherwise. I technically act as sort of a resource person outside the job. I don't see patients, and I don't give medical advice outside the job, but there are people that call me lots of times. They know me from the rural community, and they will say, "Look, I have been wondering if I should go in and see Dr. Kimball about this, and it seems kind of silly, so what do you think? Do you think it ought to be checked out?" That kind of thing.

I think maybe the extender in the rural area helps personalize the care a little, along with providing it.

Senator CLARK. The other thing, it seems to me, that you really do do is in the rural sense—that's where the manpower problem is. I don't remember what the exact national average of doctor-patient ratio is. It must be 600 or 700, 800, something in that area, but in Iowa, it's 1 one to 2,000. Obviously, in Clarke County it is 3 to roughly 6,000 or 7,000, 8,000—so it's 2,300 per physician, so it is higher than the State average.

Well, it does seem to me that that's where you have the greatest need for physician's assistants or nurse extenders, whatever the right term is. You do provide that function to a rural area that might not be so necessary in a metropolitan area, where you had a doctor-patient ratio much smaller.

Mrs. DIEHL. People in rural areas tend to put off seeing—seeking medical help until they have a real problem, so that your preventive care is lower, because of the availability of people to deliver that care.

Senator CLARK. The other thing about it—any of you maybe could answer this—I don't have the statistics in front of me, but I should think in a county like Clarke County, and this would fit four-fifths of the counties of Iowa, that you have a higher percentage of elderly people who, in turn, have a higher percentage of medical needs, health needs. Do you remember offhand about how many people are over 65 in Clarke County?

Dr. KIMBALL. One out of every 8.

Senator CLARK. That's very very high. Here are some statistics on what I was saying a couple of questions ago about the maldistribution of physicians in a rural area. If you take—this is national now. I was talking about State figures earlier in my opening statements, but nationally, if you live in a town of less than 10,000, the doctor-patient ratio is 2,500. In other words, every physician had an average of 2,500, which is about what you have, whereas to take the other extreme in a community of more than 5 million, the patient-doctor ratio is 500 instead of 2,500, so it's four or five times as high in the smaller nonmetropolitan county than in the larger nonmetropolitan area.

There is a direct relationship between size and patient-doctor ratios, so I think that, in a sense, is why the physician's assistant or

nurse practitioner or extender is so much more important in the rural areas, to be able to extend in that way.

I was interested in something you said, Dr. Kimball, earlier about the fact that you feel that the supply of family practice physicians is on the rise in Iowa, and I think, from what you have said, and other information that we have seen, that that's clearly true. Do you think they will go to the small towns? They might just go to the cities.

Dr. KIMBALL. There's been some fear they would be swallowed up in the metropolitan areas. They don't have family physicians. They have specialists, so that the typical family in Des Moines has an obstetrician, pediatrician, internist, cardiologist, looking after them, but they don't have one guy who looks after the whole human being.

Most of the training programs are in the metropolitan areas, and the things that attract doctors' wives are in metropolitan areas, most of them. There are some doctors' wives that aren't attracted there, but most of them are, so that there may be a problem with that.

If you took the 50 people who are in training right now, you could put them in Des Moines, and they would be swallowed up, and the health care would probably not be altered significantly in Des Moines at all.

Senator CLARK. In other words, we can't be sure that there is increased family practice?

Dr. KIMBALL. But we do have an increase, which is heartening. That's better than nothing.

Senator CLARK. It's a step in the right direction, if we can just get them out there.

Dr. KIMBALL. We do have programs, which you are probably aware of—there's a MEACO program, which tries to get medical students out into the small hospitals. There are receptive programs, where we try to get the students to come and live in our homes for a month. There are receptive programs where we have the residents from these programs come out and live with us and work in our offices for a month.

I think there is a great deal of communication between the medical society and medical doctors and medical schools, trying to get people out in rural areas. I don't want to get off on something else, but there is one thing I would like to bring up, and it has to do with a recent article that was in the Register and Tribune about a program that is taking place in our area that is federally funded that is being put on by the Osteopathic School in Des Moines. I think it is an interesting program.

They are going in a Winnebago to small town that don't have doctors.

Senator CLARK. Winnebago County? In a Winnebago camper.

Dr. KIMBALL. These medical students and instructors are going into these towns and spending 2 days a week in each town, and it is interesting that—I have some problems with it, in that I don't know who's at fault in not contacting the other, but it would be nice if we had some coordination between that activity and our own, so that when they are gone, they revert back to us, and if we don't know what is going on there—again, this is a matter of recordkeeping.

We have some problems, but there is about a quarter of a million dollars going into that project, and I think it could be interesting, and perhaps interest kids into going into rural areas.

Senator CLARK. It is an interesting idea. What is your experience, both of you, in terms of this reimbursement of nurse practitioners under title XVIII, title XIX? I suppose you are so closely associated at all times, that it may not be such a great problem for you. In other words, you are in sort of the direct supervision all of the time, or is it a problem?

Dr. KIMBALL. It's not been a problem, because we are in direct supervision.

Senator CLARK. Do you see anything that you feel we ought to be doing, legislatively, at a national level, that we are not doing, that would be of help in terms of rural health care, as you visualize it?

Dr. KIMBALL. I wrote you one time a letter and said that if you really wanted doctors in rural areas, don't have them pay income tax.

Senator CLARK. Don't have them pay income tax. I'm sure it would work.

Dr. KIMBALL. I think you would have such an influx of doctors in the rural area that you couldn't take care of them.

Senator CLARK. Or lawyers.

Dr. KIMBALL. It's not going to happen, but I think the financial thing has to be looked at.

Senator CLARK. You see that as the principal problem. It's one of them.

Dr. KIMBALL. When you recruit a doctor, you recruit his wife. You don't recruit the doctor. He is going to be doing pretty much the same thing wherever he is. What kind of schools do you have? What kind of activities are the kids going to have? If you can move the wife, you are probably going to get the young doctor.

Mrs. BROWN. That's where the public should come in. If you are promoting another doctor in the area, then the public should be solicited to try to make it as attractive, anything to make it attractive to the doctor's wife.

Senator CLARK. Anything else any of the three of you would like to add to what we have been talking about? Are there any questions or areas I haven't commented on?

Mrs. BROWN. This doesn't fall into Ann's category, but there is—I think we probably have as much or more of a problem with dental care, which falls under health care. We have a young dentist in our town who divides his time between Osceola and Chariton, and he is crying "help." He is trying to encourage—he is from Chicago, was born and raised in Chicago. He is trying to encourage his friends to come to southern Iowa. I asked him about a dental hygienist, if perhaps this wouldn't be of help to him, alleviate his load of just cleaning teeth, and he said it certainly would, if the public could be educated and accept a dental hygienist to clean their teeth, rather than the dentist, and perhaps Ann has had some problems with people accepting her, rather than seeing the doctor—I don't know—but I would think it would fall into, perhaps, the same sort of deal.

Senator CLARK. What about that, Ann?

Mrs. DIEHL. I can only think of one person in 2 years that I have known that I had a problem with, and the lady said she didn't want me to check her child, and I was still in my schooling phase then, but Dr. Kimball set the situation up at the office in the best possible manner. No one has ever had to see me ever. A lot of clinics will start out scheduling all the walk-ins through their physician's ex-

tender, in order to build up his practice, and sometimes they do that with a physician.

Mine is set up so that if the doctors are full, then they say that Mrs. Diehl, the nurse practitioner, has thus and thus time available, so you can see her, or you can see one of the doctors at the other time, so I don't think anybody has ever felt I was crammed down their throat. I am as busy, most of the time, as I really want to be.

Senator CLARK. Let me ask one last question, Dr. Kimball. Do you think that a part of the answer to rural health care, greater rural health care, is nurse practitioners? Is that a part of the answer, in terms of your experience, around this State, other parts of the country?

Dr. KIMBALL. I don't really think so. I think that it is—Ann is very useful to me, and she does a heck of a good job, but I don't think that the physician's extender is the answer.

Senator CLARK. I didn't say the answer. I said part of the answer.

Dr. KIMBALL. I'm afraid it is going to get turned into that. I think the answer is more physicians, which medical schools are working on, but, again, it takes 4 years to produce an M.D., and there is no quick way to do it.

I think people want a quality medical care, and I would hate to see us spring a bunch of small satellite clinics up, staff them with physician's assistants or extenders, and then try to fit in an increased number of doctors into that program.

Senator CLARK. If you don't feel it is part of the answer, why do you have one?

Dr. KIMBALL. It's an answer right now. I am talking about 10 or 15 years down the road. I don't think that we want to gear up to producing a number of physician's assistants, nurse practitioners, and then also be gearing up to try to produce more doctors.

Senator CLARK. You think we will have too many?

Dr. KIMBALL. Too many.

Senator CLARK. Is that the trend? Would the trend really show that in rural areas—which I am speaking of—

Dr. KIMBALL. We don't know what it is. We don't know where these residents are going to go.

Senator CLARK. No; but we know what it has been over the last several decades, in terms of the trend as established as of today. We know that there are not all that many more people going into or coming out of medical schools.

Dr. KIMBALL. Well, the medical class at Iowa since I went to medical school—I graduated in 1964, and I graduated in a class of 100. Now it is a class of 200, but they have residency programs to take after that, so if you put 100 doctors into the system at one year, and then you put 200 in the system another year, it takes a while to develop that. I think probably Dr. Azneer can tell us what growth the osteopathic college has taken.

Senator CLARK. So that you visualize a time when nurse practitioners and physician's assistants can be replaced by physicians themselves in the small towns of Iowa, or the rural areas of Iowa?

Dr. KIMBALL. Well, I think they are going to be in centers in Iowa, and I think people are going to change, as you spoke of, the county line concept. I think there are going to be centers where people go, and I think the biggest problem is transportation to that center. You take a doctor and a horse back in the 1900's, he did make

house calls, but it might be that you waited all day for him to make that house call, where now there are very few places that are further than 15 or 20 minutes away from some type of medical care.

Senator CLARK. You are in a better position to make this judgment than I am, because you are living in it, and I am not. Just in looking at it as an outsider, I don't see the trend for physicians back into the rural areas over the last several decades. My guess is that your medical class was larger than the medical class, say, 20 years before you. I don't really know that, but my guess is that it was, and yet we seem to have a lower physician-patient ratio in your time than before.

Dr. KIMBALL. In my class, the ones that I mostly associated with, we have one in Boone, one in Lamoni, one in Osceola, and one in Centerville that are in family practice.

We have several in Des Moines in specialties. We have several in Iowa City in specialties. I think if you will study the trends of the recent graduates of Iowa, and the recent developments of the residency programs in the State of Iowa, I think that that trend will show you that more of the people are staying in Iowa that are taking their training in Iowa, taking their residency in Iowa, and I would hope that that will reverse the trend that you see.

Senator CLARK. That you have seen in the last several decades. Thank you very much. I appreciate it. We are going to take again about a 3- or 4-minute break, and then we will have questions or comments from the audience.

[A short recess was taken.]

Senator CLARK. I know that Dr. From from Centerville is here, and I wanted him to start, because I know he has some interesting ideas and thoughts in this area. So come right up here and use the microphone, or anywhere you would like.

STATEMENT OF DR. PAUL FROM, CENTRAL IOWA HEALTH SERVICES, INC., DES MOINES, IOWA*

Dr. FROM. Southern Iowa, as we have discussed this morning, is a medically depressed area, and it would appear that it has very little hope of improving that situation in the future. In late 1975, the number of physicians in Centerville asked the chairman of the St. Joseph Mercy Hospital board of directors in Centerville for some help.

They stated that the hospital facility there was not the kind they wanted, that they could not utilize it properly the way it was set up, that they wished to have a connection with a medical center and group of specialists, that their patients were going all over the country for medical help, that followup was too difficult with this widespread referral area, and that rural Iowa did not have equitable care that the people in the larger cities had, and that this was not fair to those people.

They wanted to set up a comprehensive medical care system that was not being met by their present referral system. They suggested to the chairperson that I be contacted and help them and help organize and try to solve that problem in some way.

On December 31, 1975, we had our first meeting, and at that time it became apparent that if we were going to develop a more efficient

*See p. 296 for the prepared statement of Dr. From.

delivery system for health care for that particular area, we would have to go into some modern technological advances, especially a telecommunications system, or some other system which would utilize modern technology, and develop this to the hilt, or else we would find that there would be too much delay in receiving reports, and that health care would be too costly to the patients if reports were not prompt.

We wanted to develop a system which would encompass total health care, and we thought this system would solve the Centerville problem, but not necessarily solve the problem for the entire State of Iowa.

We felt this would provide a reduction in the cost factor, and help with recruiting physicians at the rural level, because of the intimate association they would have with urban specialists. There would be a rapid result from all the referrals in that there would be equitable health care at the rural level and a cost-effective level and that there would be a chance for ongoing education of the physician, and the paramedical specialist.

In the past 2 years, I have been interested in developing and trying to develop some leadership in developing alternate methods of health care delivery. The board of directors in Centerville knew this, and I looked to their physicians and need for this leadership, because I had had some experience with Blue Cross-Blue Shield in Des Moines through some innovative and experimental programs that Mr. Nugent and the staff had tried to develop.

I looked to Mr. Nugent, the president of Blue Cross-Blue Shield, for consultative help in developing this project. I knew that Blue Cross-Blue Shield was one of the few Blue Cross-Blue Shield programs in the country that keep administrative costs at a minimum for the medicare and medicaid program, that it had a wealth of talent, and was exceedingly innovative, and it was highly regarded in our own community levels for efforts to contain health care costs, so it seemed natural to me to seek their help.

With that help, we developed a joint venture plan which we call the Central Iowa Medical-Surgical Associates. We now have 27 people who belong to this venture, all physicians, and will have very shortly 31 physicians.

This encompasses the office practice and the hospital practice of medicine. The system is now in operation; however, it is used in old and antiquated methods of recordkeeping, but it is a system for total referral of patient care.

We have asked for Miter Corp., through Mr. Bennett, for help in this, and Northwestern Bell Telephone Co. has offered as much help as they possibly can give us. The Governor of Iowa has expressed interest especially to utilizing the emergency transportation system of the Iowa National Guard helicopters for those in the Centerville and Lake Rathbun area. Projected population for the Lake Rathbun area in the summertime is projected at 100,000 per weekend.

The Governor is also, of course, very interested in rural health care in Iowa. We have developed satellites through this venture. We have opened one in Moulton, and are starting one in Moravia, and hope to have another one in Seymour. These are visited two afternoons a week by doctors.

The one in Moulton is staffed by an LPN. Probably at the appropriate time, these satellites will utilize extenders, but these ex-

tenders will be under very close supervision of the physicians through the telecommunications system.

Other areas in Iowa are looking to us for help. If we can work out the mechanisms for this kind of system, I think that we could, with this method, enhance the capability of quality care. With the additional volume, we could look for even more cost effectiveness and containment, and even decrease the health care cost of the systems as hospital types change, satellites develop, and so forth.

The cost effectiveness of this sort of system is well documented by studies of the Miter Corp. We envision a computerized medical record with a computer stored at the city of origin for all patients, and to which all physicians in the venture can have access, but we would utilize augmented and narrow-band telephone wires for black and white television communication, over which we can send X-rays, electrocardiograms, electronic stethoscopes, microscope slides, pulmonary function data, and blood gas data.

I believe that if we can develop this system, we would have one answer to a great problem in rural health care; that is, of bringing the rural physician and urban specialist together almost at an eyeball-to-eyeball basis, develop the sense of camaraderie there and utilize the medical centers in larger cities much better than they can be utilized, and especially those in the rural areas.

Senator CLARK. Thank you. You see this as a case of referrals, but you would use satellite clinics, and that sort of thing?

Dr. FROM. Yes, we envision these satellites feeding into the rural area and being under direct control, and the rural area being in communication directly with us in the urban area, that we would be their tertiary areas for medical care, that we would give comprehensive care; that is, if a person was referred to us, and we happened to pick up another abnormality, we would treat that before sending the person back, or at least work out the problem, rather than the old system, in which you handle only the problem referred to you.

Senator CLARK. Now, do you see physician's extenders or nurse practitioners as playing any role in that?

Dr. FROM. Yes, especially in the satellite area. In the Centerville area, they have four physicians in one clinic there at the moment. They don't feel they need any physician's extenders there; however, they can only get out into the satellite areas two afternoons per week; or, at the most, four afternoons per week if they all enter into it. This doesn't provide morning care or weekend care. The physician's extender would then be very important there, but there would also be a constant communication between this satellite and the rural area through this telecommunications network. That is, a physician's extender would not be on his own completely. He would only be as close as a television monitor.

Senator CLARK. Thank you very much. We appreciate your coming over. Are there others that would like to testify, talk? It's the same thing. Each of you now give us your name and address for the record.

STATEMENT OF MARY LOUISE FILK, DES MOINES, IOWA

Ms. FILK. Mary Louise Filk from Des Moines, and we have had a good overview of the versatile ways of meeting the physician services that is one portion of the medical care system, but we haven't

heard the particular problem in addressing medicaid or medicare reimbursement for the cost of—purportedly there are many many people in nursing home care who do not belong there. There are people in custodial care who do not belong there who, through the minimum of home care for the maintenance of chronic disease and illness, could be maintained in their homes, and frequently would much prefer it. The difficulty of the fact that these costs for nursing services are prevented from billing for maintenance care, chronic illness care, I think is one of the biggest weaknesses in our system, and that's part of the so-called health system. It's not necessary that it's part of the physician delivery system, although it is frequently delivered under a physician's guidance.

Now, it doesn't take a physician's direct order to say how many times a nurse will make that judgment when she visits a home. I am not a nurse, but I think it is very important to address this part that is not covered currently, and how important that it is.

Senator CLARK. You think it would be more efficient, in terms of costs?

Ms. FILK. Not only more efficient, but it must be allowed and encouraged that medicare and medicaid reimburse for the home visits for maintenance health care and preventative health care.

In developing, we heard about the good example of the physician's assistant who had direct contact with the parents and encouraged them to come in for immunizations, but our immunization level, nationwide, is back considering our state of knowledge right now. I think that there are other areas that—such as nurses, child health clinics, and others—that if they were encouraged to expand, this would be a great help.

Senator CLARK. Good, excellent.

Ms. FILK. I think we have to address something, and certainly we do need to expand physician care.

Senator CLARK. This is true. There are many aspects of this that have to be looked at, in addition to health personnel, hospitals and facilities themselves, and how that fits into this question.

Ms. FILK. Another problem we have run into in trying to find facilities for childhood conferences, and others—hospitals are penalized if they allow their space to be used for other than the beds for care, in the fact that their cost of service is based on the number of beds, their staff, and so forth. They have to be staffed up for emergency care, and for what would be reasonable, and for a peak load, but when they are penalized, if they allow a portion of their hospital use for clinic type service, or a child health conference, cut-downs on what they are reimbursed, then it makes it difficult for them to justify to their board allowing this more versatile use of the facility.

Senator CLARK. Anyone else?

**STATEMENT OF MELVIN RITTGER, ADMINISTRATOR, SIOUX CITY
FAMILY PRACTICE RESIDENCY PROGRAM, SIOUX CITY, IOWA**

Mr. RITTGER. Melvin Rittger. I am the administrator with Sioux City family practice residents program, and I think for the purposes of the record, it should be mentioned that I believe there are 123 family practice residents in training in this current fiscal year. I think there were a couple different numbers.

Senator CLARK. There are 123 in training at this time?

Mr. RITTGER. It takes 3 years to complete the program. They are all at different stages. The Cedar Rapids program has been up and running for some time.

Senator CLARK. I have seen that one. It's at Mount Mercy?

Mr. RITTGER. Mercy and St. Lukes. The Sioux City program, this is its first year. Davenport is in its second year, and I think both of the Des Moines programs have been in operation for 3 or 4 or 5 years. I think they graduate something like 35 or 40 this year.

Senator CLARK. We were talking earlier with Dr. Kimball that the rural areas are going to get a fair share of those, or is there any way of knowing?

Mr. RITTGER. I think the College of Medicine at the University of Iowa is keeping pretty good data on where these people are going. I have seen some of it, but right now I can't recall.

Senator CLARK. We will check that. We will get the exact figure.

Let me say to you, and to others that are here, that on the back table we have got a little form here that says,

If there had been time for everyone to speak at the hearing on rural health care, I would have said—

so if any of you are really shy, or don't have an opportunity, and want to say something, get something on the record, fill those out and mail them to the addresses right at the top, and they will be put in the record as given, so anybody that doesn't have time, we would be pleased to have you fill this out. Someone here had a comment.

**STATEMENT OF ORRINE S. KIRCHHOF, DIRECTOR, HEALTH MAN-
POWER RECRUITMENT CORPS OF NORTH-CENTRAL IOWA, FORT
DODGE, IOWA**

Ms. KIRCHHOF. Last Tuesday evening, we had Roger Tracy from the University of Iowa, and he presented a program to our board, which is the Health Manpower Recruitment Corps of North-Central Iowa, and he seemed to hold very little hope for graduating physicians entering practice alleviating the shortage problem, due to the fact that we have so many physicians in their sixties and seventies.

For instance, in Fort Dodge you have 24 physicians in their sixties and seventies, and in Webster City, 10 physicians, of whom 6 are over 60 years of age.

Senator CLARK. He felt there might be replacement, at least for older physicians, but not much addition?

Ms. KIRCHHOF. The statistic he used was they projected it would be 1990 before they will gain anything.

Senator CLARK. Before they will have more than they have now?

Ms. KIRCHHOF. Due to the ones that will be retraining into specialties, retiring, or death.

Senator CLARK. All right. Good. That's interesting to have, and we will get in touch. I have been down there a couple of times talking with them, but not very recently, and it would be good to have their statistics.

STATEMENT OF VIRGINIA PETERSEN, PUBLIC REPRESENTATIVE,
MEDICAL ASSISTANCE ADVISORY COUNCIL, DES MOINES, IOWA

Ms. PETERSEN. Virginia Petersen, from Des Moines. The problem I think Mrs. Hill mentioned about misplacing people, people in nursing homes that don't need to be there, or custodial care that don't need to be there is that they need to provide care in the home, or some other level of care. The thing that always comes up is, would it be less expensive, and the thing that doesn't get said is would it be better for the person.

Senator CLARK. Wouldn't it be both?

Ms. PETERSEN. Well, not always. In Iowa, medicaid dollars will not pay for custodial care, so a person who is unable to pay for his own care costs the State so many dollars, and there is not Federal reimbursement for the custodial care, so the thing that we are hearing is that by getting the Federal dollars, it doesn't cost us any more in intermediate care facilities.

Senator CLARK. I see. It doesn't cost the locals as much, but it does cost the taxpayers as much.

Ms. PETERSEN. Yes; but it doesn't cost the DSS (Department of Social Service) any more out of their budget, and the thing that hasn't been addressed is the person. They don't need to be in there.

Senator CLARK. Anyone else?

Mr. PUSTKA. I just had one point that came in mind in the discussion in the last half-hour, and that is that it's been my personal experience—and, of course, that's what I speak from—in talking to family practice residents in training programs, and physicians in practice, that an overriding principle of thought or motivation on their part to come to rural settings and practice medicine is not just the referral capability or the continued medical education facility, but it is group practice with another physician, or physicians in a rural setting with hospital facilities.

Senator CLARK. Yes.

Mr. PUSTKA. Like the town of Madrid of 2,500 with no hospital. It's very difficult for—it's one thing to put a physician's extender there, and it's one thing to get a doctor to come to a little town with no hospital. Now, not being a physician, I can't do the thing in the hospital that the physician can, but he is trained to do that, and without that hospital in that little town, and with just one guy instead of a partnership of two, or group of family practice, which is a very workable thing, I don't think, you know, turning out a thousand doctors a year in Iowa is going to help get them distributed like they should.

Senator CLARK. That's a good point. In fact, Dr. Kimball said something to that effect in terms of the fact that you need a facility there, a hospital as well, that the two of them go together, along with some kind of joint practice. It's probably true that if you don't have that facility, your likelihood of attracting physicians, particularly in the plural is aggravating.

Anyone else? If not, I want to thank you. I think it's been interesting to me. This is the first of six, as I said, that we are going to do, and

we are looking at all different kinds of things, from the center at Red Oak, to the kind of thing we are talking about here with Madrid and Osceola.

It seems rather clear that there is a trend—well, it is clear that there is a trend in the past. At any rate, that trend that's established is that we have some real problems in terms of health personnel, distribution in Iowa and across the country in rural areas.

We hope that these most recent trends in family practice will reverse those over a period of time. Obviously, even if successful, it is going to take some time, and it seems, at least from the limited testimony that we have had today, that these physician's extenders, such as we heard in Madrid, or nurse practitioners, such as we heard in Osceola, are part of the answer.

Obviously, ultimately we would hope that we can also develop more physicians, as well. It's been helpful to us, and I think helpful to the Senate, and we will be continuing these. I do want to say that we are very grateful to the community here at Grimes, and the people associated with the American Legion Post here for their hospitality in letting us use this room.

I have got a note here that says that anyone who spoke from the floor should please leave their name and address with Warren Oxford, and we will send you a copy of these hearings, and we might say that anybody else that wants a copy of these hearings, which will be published probably in 2 months, just leave your name and address here, and we will be happy to send those hearings to you.

I thank you very much. We are going to go over to Madrid now and look at the clinic.

[Whereupon at 12:30 p.m., the subcommittee recessed, to reconvene at 2:30 p.m., October 14, 1976, in Treynor Elementary School auditorium, Treynor, Iowa.]

RURAL HEALTH SERVICES IN IOWA

THURSDAY, OCTOBER 14, 1976

U.S. SENATE,
SUBCOMMITTEE ON RURAL DEVELOPMENT
OF THE COMMITTEE ON AGRICULTURE AND FORESTRY,
Treynor, Iowa.

The subcommittee reconvened, pursuant to notice, at 2:30 p.m. in the Treynor Elementary School auditorium, Hon. Dick Clark (chairman of the subcommittee) presiding.

Present: Senator Clark.

STATEMENT OF HON. DICK CLARK, A U.S. SENATOR FROM IOWA—Resumed

Senator CLARK. Hearing will come to order. I'd like to welcome you to this hearing of the U.S. Senate Subcommittee on Rural Development. We're a subcommittee of the Senate Agriculture Committee. This is one of a series of six hearings, the second really of six hearings that we are holding this month, to investigate rural health care in Iowa. I'm pleased that witnesses have agreed to come, others to visit, about this important topic. I believe that all of us can come away from this hearing as we did in our last hearing 2 days ago in central Iowa with a somewhat better understanding of the health care situation in Iowa's small towns and rural areas, and more importantly, what we can perhaps do about it.

Now, the Iowa hearings and visits to health clinics are part of an ongoing effort of this subcommittee to study the problems of rural America generally, not just health problems, but this subcommittee is involved in looking at the whole rural development question to try to analyze current efforts to address these problems and to determine the proper and most effective future Federal role in these areas. What's the role of the local community? What role does the State have to play, if any, and what role, if any, does the Federal Government have to play?

Now, last February Senator Leahy, of Vermont, chaired meetings of this subcommittee up in Burlington, Vt., and there we learned about the special circumstances of those living in rural New England and about some initiatives and grassroots activities to deliver health care services to these people. We learned that attempts to attract health personnel to some of the more remote areas were stymied by archaic medicare reimbursement regulations and we committed ourselves at that time to work in Washington, D.C., through the committee to try to revise those regulations.

Now, basically the problem with medicare reimbursement is simply that nonphysician health personnel, the various kinds of health personnel extenders, physician extenders, nurse practitioners, and so forth, cannot now be reimbursed under medicare and medicaid. To put it more specifically they could be, but the Department of Health, Education, and Welfare has interpreted the law in such a way that they are not, so we need to change the law, or at least make the law specific in making that possible if we are ever going to hope to have physician assistants, nurse practitioners, and so forth, continue to operate and expand. Now, we also learned at those hearings that communities need financial assistance in the stages of establishing primary care clinics. In fact, I offered an amendment about 2 months ago which passed the Senate and ultimately became law which provides low-interest loans to needy communities to help them start the clinics. Sometimes we call them satellite clinics out into the rural areas.

Now, we are in Iowa this month to assess the special needs and problems of rural America and in particular in this area. Next year, the subcommittee intends to conduct similar investigations in Appalachia and through the South. This is truly a thorough national investigation of health care in the rural areas and, of course, there are a lot of similar problems all over the country. Our goal is to return to Washington with some concrete proposals to fulfill the promise of providing adequate health care services to all Americans regardless of whether they live in the most affluent suburbs or the most remote rural communities, at least to the best of our ability.

Now, this objective can never be accomplished without the help of people in these communities, and particularly the health personnel, people who have had some experience and knowledge in terms of what works and what does not work. Legislators cannot simply sit in Washington grappling with rural health issues with which we have little or no day-to-day experience. The insulation of many Federal policy-makers from practical reality has very often led to the ineffectiveness of several of these programs. In turn American citizens have lost confidence in the ability of the Federal Government to confront major national problems. For this reason we are here today to listen to those who have intimate knowledge about the health needs of rural Americans and are actively involved in trying to serve them more effectively.

Our Nation has spent millions of dollars in the past few years to encourage health professionals to practice in admittedly unserved areas; however, these efforts have not been very successful on the whole. Therefore, health personnel are still clustered primarily in urban and suburban areas. Without new Federal initiatives, based on our experience in States like Iowa, the geographical maldistribution will continue. Now, I'm not talking about having a physician in every community of the State. I think for reasons that we will be discussing here that's neither practical nor desirable, but on the other hand, there is still, I believe, a very bad maldistribution between the largest urban areas of this country and the small communities, the rural communities.

Iowa's no exception to that particular picture. While the country as a whole, for example, has 130 general care physicians—130 for

every 100,000 people, Iowa has less than half that. We have 55. Now, that's about one general care practitioner for every 2,000 Iowans. The national average by the way is 1 to about 763, if I remember correctly. So it is much, much higher.

If you look at the statistics the Department of Health, Education, and Welfare publishes, you will see that in the very largest cities in this country, those of over 5 million, we have one physician for about each 500 persons. If you look in communities of under 10,000—perhaps that's not the best judgment to make—but if we look at that for the moment, we see that there is only about 1 for every 2,500, or about 5 times as many.

Now, again, I think there is a great danger in simply looking at county lines or sizes of communities. That's only one way to look at it, but if one looks at it in that method, and to try to find some measuring stick in our State, we know for example that about half of all the physicians in this State live in 6 of the 99 counties. We think we have a problem. And to make matters worse I might say in this State one out of every three physicians is 60 years of age or older. So we have some problems.

Now, I might say with regard to this particular part of this State, the Department of Health, Education, and Welfare has concluded that parts of 5 counties in southwest Iowa: Harrison, Shelby, Cass, Montgomery and Mills, can be considered medically underserved areas. Now, the Iowa Health Manpower plan for 1975, the plan that was made up here in the State by the people from this State, has determined that Harrison and Montgomery Counties have especially severe health manpower problems.

In those two counties a third more general care physicians are necessary to meet the current demand according to their estimates. Now, as you can see this is no time therefore to be complacent about health care services in rural America. It is a time to take a hard look at where we've been, where we're at now, and where this Nation ought to be heading in terms of addressing the health needs of its rural citizens.

I look forward with a good deal of interest, particularly today, to hear what's happened down in this part of the State. Some interesting, innovative, and rather exciting things I know are happening with regard to the clinic in Red Oak, the family care center in Red Oak, and its satellite in Malvern where we've just come from, and we are also very interested in hearing what's happening in the Shenandoah, Essex care centers as well. So with that by way of simple introduction we are going to go now to Dr. Fickel and Dr. Artherholt.

And Eugene Burdic should be coming along, a banker from Malvern, and I think the way we are going to do this, Dr. Fickel, why don't you just start out, and then you Dr. Artherholt, and then Mr. Burdic, and I'll try to not interrupt you too much, and just let you say anything you would like to say about how it developed and anything you've got prepared, and we'll take about another half hour after that for questions. I'll have questions and so forth, and then we will go on to the second panel, do the same thing, and then we ought to have an hour and a half, hour maybe, something like that for questions or comments from the floor.

Now, all of this obviously will be made a part of the record and will be printed, made available to every Member of the Congress.

The members of the Rural Development Subcommittee will have a particular interest in it, and if those of you here would like copies, if you leave me—leave your name with us before you leave, we'll be happy to do that. I would like to say, also, that we have sheets of paper here for those who may not have an opportunity to testify who would like to say something about their community or their experience. Anything that you'd like to have in the record about these hearings, and if you will fill out these and mail them to me within 1 week, the address is on the sheet, they will be made a part of the hearing as if presented here. They are in the back of the room, I'm told, the sheets, and self-addressed envelopes, so we are going to make it easy for you. We'd be happy to hear anybody's judgment on anything you'd like to discuss with us with regard to rural health care. Well, let's just go ahead with the panel at this point. Dr. Fickel, will you proceed.

**STATEMENT OF JACK D. FICKEL, M.D., MEDICAL DIRECTOR,
FAMILY CARE CENTER, RED OAK, IOWA***

Dr. FICKEL. Thank you, Senator Clark. What I'd like to do first is make some general comments concerning the concept of recruiting, particularly physicians, but it is also applicable to other health care personnel for rural communities, then briefly explain what he did and how we tried to go about fulfilling recruitment and supplying more health care to the general area.

First of all, in recruitment of physicians we have to consider the need, and the need is quite obvious. As Senator Clark has alluded to, there are too few rural physicians. The majority of these are in solo practice which poses a problem. Most of us in solo rural practice are getting old or are too old actually to participate in new ideas to keep abreast of the changes, to actually do those things necessary to maintain the quality of health care and the availability of health care that's necessary today. We are locked in a fixed community relationship. A fixed community role, partly by habit, partly by the workload and partly by the fact that it simply—that's the way it has been for a long time in practice, and that's the way it is going to be on out because it's too much of a struggle to change. Fortunately I hope some of us have not reached that age or that degree of lack of pliability to accept new ideas and participate in them. On the whole, I think those are the three primary problems of the existing physician corps in rural Iowa. There are too few of us, too many of us in solo practice, and too many of us are too old. We also are faced with the problem of too many patients.

In our practice basically the type of medical practice we engage in is simply of a matter of putting out first, treating emergency care, treating the acute illness, and not having time for preventative medicine and entering into the general area of community health. We are always on call. Twenty-four hours a day we are available to our patients, and although we are greatly loved for this, we are also killed off by it. We are also putting in long hours in the office, long hours in the hospital emergency room, and long hours answering the phone in the middle of the night, delivering babies in the middle of the

*See p. 300 for material submitted by Dr. Fickel.

night. The patients are not really getting the quality of care they need because of the need. I am always sorry for the patient that I see or someone else sees at the end of a 10-hour working day. You simply do not function as a physician as well as, whether you are a truck driver or in any other business. In fact, I think there are Federal regulations that won't let you drive as many hours a day as a physician works, at that point we may be called upon to deliver your baby, for example. We have inadequate time for continuing education and learning new techniques in upgrading the level of patient care in our own practice. Also, we do not have time to upgrade the level of care and quality of facility in our local hospitals. The hospitals themselves, well meaning as their boards may be and their administrators may be, simply do not provide those levels of function that—in new techniques that are necessary unless the physicians are the ones who push the hospital into that situation. They look to the physicians for that kind of leadership.

Another problem that I think we are all aware of as citizens of southwest Iowa are the changes in the demography of the patient population itself, and the most obvious one is that our patient population is older. There are fewer and fewer young couples. You can go to church and see it. There are fewer kids crying in the church. There are fewer kids and young families in the community because there are fewer jobs to provide young growing families. In Treynor locally you live close in enough to where the jobs are provided that you have a higher young population, but overall across rural Iowa the trend is to an older and older population, and indeed rural Iowa has a percentage in the United States among the highest. I think we are perhaps the second highest in the States.

Senator CLARK. That's right.

Dr. FICKEL. For the percentage of people who are aging. This affects physicians in an interesting and perhaps unique way. Obviously older people require more health care, so it increases the most when we have 500 patients who are 65 and older, we have more health care requirements than if the patient load were 50-50—under 65. We also have fewer opportunities of pediatric care and the care of younger patients so that it makes it more difficult for us to practice to keep abreast of adequate care and adequate training in those areas. There's less—there's less stimulation for the physicians to—when they practice with a practice limited to geriatrics, and when you are family practice your interests are over the whole gambit and over the whole scale of the age group. Well, that really is the need. The need is for more and better distribution, as Senator Clark said, of physicians in rural areas. Just again I want to emphasize. I agree this does not mean a physician in every town. It does not mean that every town which had physicians in the past is going to have it. One of the reasons that we don't get new physicians is because of the nature of the need. Unfortunately that in itself makes it more difficult to recruit young people into medicine in rural Iowa.

Where do we look for recruits? What availability of the recruits? I'd like to break that group down into three basic groups. One is physicians who are trained outside the United States. There's been a great influx over recent years of non-United States trained physicians. Another area is U.S. trained physicians, but of, as I like to think,

lesser quality, of lesser training. Those who have had 1 year of rotating internship rather than going ahead with a family practice residency or internal medicine residency or other postgraduate residency. In other words, lesser training but more readily available group; and there is a group of those, also. The third group is the high-quality well-trained, well-motivated physicians who aspire to excellence. These are the real cookies you want. These are the ones who are going to maintain the fine quality of health care in primary health care in the United States, and we want to get them into rural Iowa and into rural America.

Unfortunately, it is easier to get recruits from the first two groups, and the groups are not particularly compatible. For if you draw the lesser physician, if you will, the physician with less qualifications into a local community then you have less chance of drawing in a physician who has the motivation to aspire to excellence; not only for the matter of competition of patient load because of peer association, because of the level of excellence to practice in the community, and after all why should a physician who is well trained, who has residency training beyond school, why should they come into the boondocks, if you will, and I can say boondocks because I was born in Council Bluffs of a farm family, not 20 miles from here, and my roots are deep in southwest Iowa. My people came here in 1852 and we are still in southwest Iowa and it isn't because we can't get away. It is because we like to stay here. But why should they practice out there? Well, one thing is that in this day and age the men and women coming out of medical school have a different attitude than they did 10 and 15 years ago. They're more idealistic. They are much more altruistic and they see a great unmet need and this makes rural practice in that respect very attractive to them. Just as many of them will go into the—get in the inner cities because of the enormous need for quality medical care. That is a challenge. That is a plus in recruiting.

Of course, the matter of plain old urban flight—I won't go into why there is urban flight, but there is in this day and age, so that rural living at least is more attractive than it was. But on the other side of the ledger why not practice in the rural area? Why not practice out in the boonies? Well, one thing is the poor image of rural, social, educational, and professional quality. The image of life in rural America is not good despite the advertising of the television of nature foods and showing all sorts of programs which are very, unrealistic about life in the rural areas. The image is not what it should be and we should correct it. The competitive workload, the patient load that we are talking about, if you put a physician into a community—I've heard many committees say time and time again, and they still say it, I just don't understand why we can't get a doctor, why he can just be so busy right from the time he gets to work. Well, of course, he could just work himself to death, but that is not what physicians want and that's not what you should expect of your physician. Physicians can go anywhere and make a living. There's a demand for a quality physician. They can go anywhere and make a living so don't expect them to come just because there's a lot of patients.

That's on the debit side rather than the positive side, the excessive workload. There's too little time for leisure and for family life and that is important in this day and age. It isn't because these physicians

that are coming out of school are selfish or that they're spoiled or anything else, but they do realize and appreciate quality or life just as the other young people do who are coming out of other professions and other occupations, and in the life that I lead, when I went into family practice in rural Iowa, this is not the kind of life that is necessary to lead, and it gave me a coronary when I was 46 years old. You have to be available 24-hours a day if you are in the solo practice or if you are an individual in practice in an isolated rural community. That's bad no matter how you look at it. The problem of professional stagnation due to a lack of continuing education opportunity and time for it, due to a lack of contact with other physicians, with peer stimulation. This is a debit. Poor hospital quality is becoming increasingly a very, very severe limitation on our ability to recruit a physician, quality physicians in rural Iowa.

The expense of providing adequate diagnostic treatment facilities for a solo practice or even two-member practice is getting staggering, not only because of inflation, equipment is more expensive, but because more and more equipment is available and necessary to practice modern medicine and to practice the way you are taught to practice in medical school. You give your patients the quality of care they need.

Well, how do you attract quality physicians? We've done it. Senator Clark just mentioned that the study showed that Montgomery County needed at least a third more, and indeed we did. We were down to seven. Through our recruitment program we recruited three which is just about right on the button statistically, and it worked out very well.

Well, aside from just what we did, one of the best ways to recruit is to form a group practice. That is a group of three or four or five physicians in a practice in a town. Another plus is to form a—or build a hospital related facility; that is the offices in relationship to a hospital. There are several advantages to that. The convenience is one, but also you can utilize the laboratory and the X-ray facilities in the hospital, and it is much more convenient, and you can practice better medicine. You need the physicians themselves in that group, the community can't do this. Need to utilize the recordkeeping system which would permit recall of information for the patient profile or the picture of the patient, so when the patient comes in you readily can pull together the information. You need this type of record system where you can have a practice profile. That is so that we can make a study of our practice of medicine, what type of patients are we seeing, what groups are we seeing, then we can get on into the area of self-assessment and peer review to find out what kind of quality we are giving, and the result assessment of how well our patients are doing with the type of treatment we are giving. This has been a neglected area in the past and in our antiquated medical record system that we've all had or known, that is practically all of us had had in our offices, it was simply impossible to pull this data together and to use it in an intelligent way.

The peer association, I've mentioned that, it's extremely important for ongoing education, for doctors to work with doctors, to share problem patients, to share reading, to share meetings that you go to to bring it back and put it together with each other. And also the competitive—the intellectual competition gives you a stimulation for a further striving to excellence.

Something more pertinent perhaps to what the individuals can do in the communities, or the communities themselves can do is the quality of the community itself. It has to have an economic base that's viable for growth of a population. This gets into the whole area of jobs, into the area of business activities, the quality of your community itself. The educational facilities, the school systems, the cultural opportunities, the social amenities. All of these things are important because you are not recruiting a doctor alone, you are recruiting a doctor and a doctor's wife, and a doctor's children. So they want to have a family in an atmosphere where it is a good place to live, and the community needs a progressive attitude. I don't mean that they have to be a bunch of wild-eyed liberals.

In southwest Iowa I think that's going to be impossible. What we need, however, are progressive attitudes toward public health, toward new ideas, toward being willing to change from the mold of the past. It's always been done this way, and it always will be done this way. A matter of changing from being able to walk into the doctor's office any time of the day or night rather than for example changing to a system of an appointment system, a simple thing like that in a non-progressive community, that's an enormous change. Many communities, individuals don't go for change at all. Other young people in the community, in the business and professional community, this is very important for not only professional peer association but obviously for social and business peer association. It is very sad for a 30-, 35-year-old newly trained young physician to go into a community where they are planning to live and they meet with a 65-year-old druggist and a 70-year-old clothier and the whole community made up of people who do not have growing children, but they tell about their grandchildren.

My colleague and I, who are in recruiting felt this rather acutely because here were these recruits, little tykes, and we were talking about another generation. It isn't important that you all have to be young, I don't have a young mania, but they have to see their young people with whom they can associate with in the community. There needs to be a broad community awareness and support of a need to improve the medical care. Not all communities feel this. They think boy, I got my doctor, to heck with them, and they don't realize that their doctor perhaps had a severe medical problem of some sort. That their doctor is 70 years old. He'd still take care of them, giving them adequate care and may be a fine doctor at that age, but he's got a life expectancy, too, and with the load that he's carrying there's an end to the road someplace. Too many communities have glided along with the stream. Why should we have recruits? Why should we be talking about any change of medical care? We are fat cats. We are covered and the age of their physicians has grown, and the retirement, the attrition by death, the attrition by inability to continue to serve for health reasons, an automobile accident or two and they can be wiped out, and this has happened in community after community. The local citizens must care and they must let the new recruits as well as the existing medical personnel know that they care. Access to potential recruits is not as easy, whether they are in any of those three groups or not. The access to them perhaps is—well, one place is the National Health Service Care Corps, unfortunately the Government

puts positions out in the field for, I believe, 2-year stints, and for those who are not going to stay on beyond that, then they will be looking for a place to practice. So this is a reservoir.

One interesting reservoir which we have not had to the great State of Iowa in the past, but it is becoming much more available now, are residents trained in family practice in Iowa. We in the past have been shipping our graduates out of State to get the residency training. When they are ready then to find a place to practice they usually stay in the State where they took the residency training, and I'm happy to say that in the State of Iowa we have a big increase in the number of residents for residencies available. They are scattered around over the State, and this is going to be a big improvement in the source of recruits for rural communities. Training in for medical students and for residents out in office practice in rural Iowa is another source of recruits. They get to know the town where they go out for a 2-week or 2-month or 3-month stint and they like the town. They get to know the community. They find out it is a good place to live. They are interested in coming back there.

Well, we—in Red Oak we were down to seven physicians. One of those was a—seven physicians primary care. One of those was a surgeon, and one an internist. We—the average age was over 60. We had had two physicians previously in the town of Villisca. When I came there we had 19 physicians in the county and that wasn't so many years ago.

Senator CLARK. Nineteen.

Dr. FICKEL. And by attrition by death, by moving away, we went down, down, down.

Senator CLARK. I'm trying to think of what the population of the county is, 13,000, 14,000?

Dr. FICKEL. I should be able to tell you off the top of my head but I'm ashamed to say I think it's down to about 12,600. It's gone down. The county population has decreased until the—since 1970. There has been a turnaround in that fortunately because we have been able to get some job opportunities, but the attrition of physicians was frightening. We still were fat cats as far as compared to a lot of communities. We had retained—we had the hospital and we had retained this number of physicians, but we weren't going to be able to very long. All of us were in individual solo practice. All of us had all of the frailties and the problems that I mentioned. We were overworked. We were locked into a practice. Our age was getting up in years. I was the last family practitioner to have come into the county, and I came in in 1953, so that was a long dry haul of any more new blood coming in. We had made studies over a long period of time.

Our chamber of commerce and our community had been active in a physician recruitment program, and we had been unsuccessful. We had gone to the service. I didn't mention that. That's another source of physicians obviously that come out of the service. We had flown to Texas. We had flown all over the country to try and recruit physicians and we had been totally unable to. We brought in some good recruits and they loved the community. It is a good community, as I think you all would agree. It had a lot of the amenities that we have been talking about, but what really shook them up was this thing about how they would have to practice medicine. They would be alone in a practice. They could go in with somebody, but really it

wasn't changing anything. They were cooled off by the idea when we'd all say, boy, you will have plenty of work, and they knew very well.

Two of us joined together to form a group practice. We dedicated ourselves to the problem. We constructed a building next to the hospital with the cooperation of the hospital board of trustees. We studied the possibility of satellites, and I joined in the program of training family nurse practitioners and became the preceptor for one, and we entertained the thought of establishing a satellite and were able to establish one down at Malvern. We set up a call system. We set about to practice, and dedicated ourselves to educational programs, talk to the family practice department at the University of Iowa about bringing in family practitioner residencies—residents, rather, and we set about then to recruit, and Dr. Artherholt, who is going to speak to you about being a recruitee instead of a recruiter, was our first success, and since then we've had two others. All three of the men we brought in to our practice are residency trained. They are all three fellows of the members of the board of the American Academy of Family Practice and we're proud of what they are doing, not only in patient care but also in stimulation to a greater awareness of the needs in medicine today and the needs in medical education so that we as older physicians now, I think, are doing a better job, also.

It is not inexpensive. We have been fortunate to be recipients of money from the Kellogg Foundation grant which does not help us specifically in treatment of patients but does provide funds for the educational aspects and helps out with the satellite program.

I would like to say that one other source of physicians that is evident in the United States today is—I got this in the mail, and it is interesting. I would like to have this go into the record.

Senator CLARK. We will put it in the record.

Dr. FICKEL. This is from a commercial organization. It came to me unsolicited, and it is a suggestion that if we sign with them, there are great opportunities and great rewards for physicians who might be interested in taking advantage of their services, and they would match physicians with communities. I know that they—I have no evidence that there was any investigation of my qualifications as a physician whatsoever. They would recruit me as a possible number that they could send out somewhere else, and I would advise communities to investigate very carefully before they would fall into this because this is like—to me, this is like the treatment of arthritis. The reason there are so many advertised is none work very well and everyone has a need for physicians, and there are lots of people trying to get into the game of supplying them, and they are doing it for monetary benefit. Thank you.

Senator CLARK. Thank you very much. We appreciate it. As you can see Dr. Fickel is one of the best informed and more articulate witnesses on this subject because he's lived with it directly. He's been very directly involved in providing rural health care and he's concerned with the problem. He's doing something about it. He has been interested in doing something about it for a good long time. We are particularly fortunate to have him here, and to talk about a great number—really almost dozens of specific considerations and problems

that are related to this problem of providing rural health care. We are very grateful to you.

Now, we are going to hear from Dr. Artherholt, and as Dr. Fickel revealed he is one of the recruitees, and I had a chance to meet him down in Malvern. We then talked to some people down there who are aware of the kind of health services that he provides on a 3 half-day basis at the family care center down in Malvern. And so you proceed in anyway you think appropriate. You are going to talk a little about your experience in Malvern and in Red Oak and so forth, so you just go ahead in anyway you wish.

STATEMENT OF WILLIAM G. ARTERHOLT, D.O., FAMILY CARE CENTER, RED OAK, IOWA

Dr. ARTERHOLT. What I would like to do is first give a little bibliographic information because it might be pertinent and develop the story of a Red Oak boy who went to medical school.

Senator CLARK. You are from Red Oak?

Dr. ARTERHOLT. Yes. And became a recruitee, if you would, and came back to Red Oak and discussed that concept and the satellite concept in some detail. I was from Red Oak, went to Drake University, and then to the Osteopathic Medical School in Des Moines. Following this I went to Wichita, Kans., to the Wesley Medical Center for family practice internship, and then a 2-year family practice residency. Subsequent to this, I did become a diplomat of the American Board of Family Practice, and a fellow in the American Academy of Family Physicians. Along the way at various times while in Des Moines and while in Wichita I was approached by a number of communities looking for a physician. It was particularly striking to me, a number of smaller communities would send representatives to the medical school or to the residency to talk to me, to take me out to dinner or whatever on a number of instances. The first two that I had were from communities under a thousand in population. One of them in particular happened to be about 10 minutes from a larger community of about 12,000, and it didn't take very long at all for me to decide that they should not have a doctor.

At that point I didn't feel confident enough to tell them this, but it was readily apparent to me that they really didn't have any business out recruiting a doctor when they had such excellent medical care within 10 minutes away. So this wasn't long until I stopped talking to the smaller communities, and why did I develop this attitude? Well, a lot of it has to do with what Dr. Fickel has talked about. A smaller community that can support one doctor probably should not have a doctor. A community should be able to support, in my opinion, three or four doctors to have any physicians at all. And why? Perhaps to contrast, I should talk briefly about what a smaller community, let's say under 1,000, arbitrarily, has to offer. Well, it has a small town living, which for many people is a definite positive, but it does also offer medical isolation. If you got a rash that you don't know what it is, you can't walk down the hall and get Dr. Fickel and say come look at this with me. I could elaborate on this, but I think the University of Iowa did a study recently within the last few years and came up with a similar conclusion; that the reason that physicians leave smaller communities, one very important factor, was medical isolation.

Senator CLARK. Let me just interrupt here a second. I know Bruce is here from the medical school. I wonder if we might make a summary or a conclusion of that University of Iowa study part of the record at this point. Is that possible?

Whatever we could do to get it summarized. We will put them at the end of his remarks, if we might. If you will just mail them to us.

In other words, the one point that you are making is this professional isolation. You just don't have the other professional help immediately accessible to you to be conferring to get a higher quality health care?

Dr. ARTHURHOLT. Right. Certain smaller communities—as Dr. Fickel mentioned, that isn't unique to a smaller community. A physician can go anywhere and make a living. If you ask my wife, she is not concerned about making a living, she's concerned about the quality of life that we are going to lead and that's important to me, too. A small community with one doctor offers 365 day coverage of the practice. That means it is hard to get away to go to Iowa City or to Boston for medical conferences. It is hard to see my 6-year-old at her dance recital which is important to me. It is hard to get time for family, and when you do leave you don't know what's going to happen to your patients.

Coverage in a smaller community can be nonexistent. I did a perceptorship in Kansas, in a town of 700. When the doctor left there was nobody, or at best, it oftentimes is not adequate. There are exceptions. Some doctors do go to small communities. I had a friend in medical school who was a year ahead of me. He went to a town of approximately 700 people in Iowa. He will be completing his fifth year and he is very active. In the practice he is well thought of. His plans are to leave general practice and go into a radiology residency. This in itself I think points up a problem. Perhaps he was not adequately prepared for what he was going into, but more likely he got into a situation that just was not tenable to him. He couldn't tolerate it, so he is leaving. The advantages of a larger town, a town that can support—when I say larger, this is a town that can support a group of doctors. It seems obvious. It seems like you wouldn't have to say it, but a town of 600 can't support a hospital. A larger town can.

Senator CLARK. Why is a hospital important?

Dr. ARTHURHOLT. A hospital today is very important. I guess I might answer that by discussing what the situation was 50 years ago. Malvern, where our satellite is, 50 years ago had no hospital, but they had three doctors. Medical practice 50 years ago was mainly out of the bag. The babies were delivered at home. If somebody fell down and bumped their head you didn't think about getting a skull X-ray because it wasn't available. And with some hesitation I would say that you, 50 years ago, didn't have to worry about legal implications if you didn't get a skull X-ray which we have to consider now. Fifty years ago practice was different. There wasn't sophisticated diagnostic techniques which are expected and necessary and part of the quality care. These are expensive. They are expensive to the patient. They are expensive to the community to set these up. In our office in Red Oak one of the reasons that our office building is located immediately adjacent to the hospital is because that means we don't have to duplicate the hospital's X-ray equipment which is very expensive.

Senator CLARK. If you are going to have quality health care through the doctor, it is essential that there be access—very important at any rate that there be access to a hospital and its facilities?

Dr. ARTHURHOLT. I have been trained, as most young physicians have, in what we call comprehensive medical care. Family practice involves treating all aspects of people and it is difficult to do that if you lose contact with them when they go to the hospital. If you are in a smaller community you have to refer everything away. I was trained to practice in a hospital, and I wouldn't go to a community where I couldn't practice in a hospital. That's all there is to it. If the alternative is to go to a small town and drive for a half hour back and forth to the hospital, one, two, or three times a day, which is an obvious impediment I—so I was attracted to a larger community. Specifically I was attracted to Red Oak. Why? Red Oak was my hometown but that wasn't why I came back. In fact, 5 years ago I was telling people that I probably would not go back to Red Oak. I went back because of the practice opportunity which was there which I did not find in many places that I looked in Kansas, in Iowa, in the Midwest, and that is a group family practice, single specialty practice adjacent to a hospital, with particular interest in things that I am interested in such as medical education, community health, and something called problem-oriented records which patients never—probably don't know what they are.

Senator CLARK. Yes. That's one of the questions Dr. Fickel mentioned. Tell me a little about what that means?

Dr. ARTHURHOLT. Well, problem-oriented records are something that evolved probably in the last 10 years; strangely enough it is just—it is merely a recordkeeping system, but it is important to many people coming out of the residencies because it enables more than one physician in a group practice to pick up a chart and see readily what's wrong with the patient. To be able to find information in an organized fashion so that if I'm seeing Dr. Fickel's patients in the office, if he is gone or ill, I can pick up the chart and not—and know what's going on and hopefully give him—give that patient the same quality of care as if Dr. Fickel was there. The older type of charting system was quite different in that it was—they tended to be one-line entries. Very brief. Noninformative which were probably ideally suited to a one-man solo practice where he knew what he meant.

Senator CLARK. Yes.

Dr. ARTHURHOLT. He didn't need to write all this down. He really wasn't that interested in analyzing his patient profile, what he was doing, but it is not—it just doesn't work in a group practice well at all. This is again something that patients probably don't know about. Most people aren't concerned about it, but a number of younger family physicians are concerned about it. I was concerned about it coming to Red Oak. I had a rare opportunity of setting up that medical record system before I even came because Dr. Baston and Dr. Fickel knew it was necessary, and they asked me to do it for them.

What I found in the practice set up in Red Oak again, peer association, coverage, knowing that I was—when I was gone I could—my patients would be covered. I would have time for family. I would be

able to be involved in medical education. I would have time for my own ongoing medical education which is important. And as a result of this I chose Red Oak.

Now, I personally feel and in observing other residents who finished the residency that I was in, a number—most of the residents are joining together, and a number of them are going out in two's and three's to form group practices with other physicians who are similarly trained. This creates a problem. What—how do we care for people in communities who cannot support a group of physicians? One solution is a satellite clinic, having a central group practice in a larger community associated with the hospital, and having one or more satellite clinics located at some distance around that larger community. A part of our practice, the family care center, has been to develop at the request of Malvern a satellite clinic in Malvern, Iowa. Malvern is a town of approximately 1,200 or 1,300 people. They do have one older physician who has somewhat of a limited practice, but they have been actively in the past trying to recruit a physician unsuccessfully.

Briefly, the nature of our satellite as initially set up would be to have a physician extender there on a full-time basis and a physician there on a half-time basis. Now, what has happened? What is our experience? Does this work? Can we recommend it to other doctors, to other communities? We don't know yet. As far as we are concerned the final word isn't in. I think I should comment about that to tell you a little bit about it why we don't know. We've been there 14 months. We started with a 5-day—5-half-day coverage by a physician and full coverage by a nurse practitioner. The utilization of the clinic did not warrant that much coverage. We cut back to 3-half-days-a-week physician coverage and about the same time our nurse practitioner resigned due to personal reasons and this left us with a satellite with 3-half-day-per-week physician coverage and no extender. This is—we have been in this type of a relationship for about the last 4 or 5 months. At this time we are actively recruiting a physician extender to live in Malvern. In terms of cost the satellite clinic is tremendously expensive. These expenses could be broken down into initial setup costs and the ongoing costs. We kept our initial setup costs to a minimum by renting part of a building—half of an office building and sharing it with a dentist. We share a receptionist with the dentist on a cost accounting basis. We certainly could not go in and build a new office building and equip it with modern equipment and have X-ray units and so on. As a result of this, the facility may be part of the reason why we have not had great utilization to date.

Senator CLARK. There's a real question of whether it is going to be economically feasible or not in part?

Dr. ARTHURHOLT. That's right. As I mentioned in the association with the hospital in Red Oak that allows our main office to use the hospital X-ray. We cannot justify putting an X-ray in our satellite office. We are talking about several thousand dollars. Our facility is adequate in terms of ability to see patients. It certainly is not the type of facility that some patients are accustomed to if they go to Omaha and have a very well-adorned, furnished office building.

Senator CLARK. But undoubtedly you are getting people there that if you didn't have that satellite clinic, they would not get the care. It's because they are too far away. It is too difficult for them to get to Omaha or Red Oak or some place else.

Dr. FICKEL. That's really why we are there.

Dr. ARTHURHOLT. That is why we are there. I think the most rewarding part of the satellite operation for me has been caring for the homebound, or at least the townbound. Those people who are old or sufficiently ill that they can't get away from Malvern. And those people are very grateful for the medical care they get, and it is a rewarding experience for me as a physician.

Senator CLARK. Let me ask you about some questions. Let me say—by the way, is Eugene Burdic here?

Dr. ARTHURHOLT. No.

Senator CLARK. OK, because I'd like to get on the record just five or six, seven things, in particular, questions that are raised in terms of your testimony. I guess maybe I will ask these first of Dr. Fickel, but please feel free to break in at any point or make any additional comments and so forth.

How large an area now do you serve, Doctor, actually? Is there any way we can think of about it in geographic terms? You mentioned the county is perhaps 12,500. You have any concept of about how many people your center serves?

Dr. FICKEL. The area itself is about 30,000.

Senator CLARK. 30,000. And so—

Dr. FICKEL. We reach out approximately 20 miles and we see patients 50 miles away, but the bulk of the patients are from a 20-mile radius.

Senator CLARK. And now there are four of you, at least in this one.

Dr. FICKEL. There are four.

Senator CLARK. And then there are three others that are operating in the counties; is that what you said? There are seven physicians?

Dr. FICKEL. Now, there were 7; there are 10 now.

Senator CLARK. There are 10 now, with the addition of the new?

Dr. FICKEL. But some of them are age limited practice.

Senator CLARK. Either of you can answer this. Perhaps you first, Dr. Fickel, what in summary are the things that we should be doing to get health care into rural areas? I mean what direction should we be going in? The direction that you are going in Red Oak, where you are bringing together a small number of physicians, in this case four, to serve a particular rural geographic area where you don't have this kind of professional isolation, is that really the answer for this State and for this country in your judgment?

Dr. FICKEL. I think that we will prove it is. It is not proved as yet, but it seems to me that this is the most viable concept in delivery of health care that we've seen yet for rural areas. This embosses the central group with a satellite in the area about it, which with regional hospitals, there will be, I think, a limitation on geographic distance. I think ideally we are about the right distance, 20 miles out to the satellite. It envisions that we would have to use physician extenders, nurse practitioners, physician's assistants. They will have to be under careful supervision and work closely with the doctors. Transportation facilities are going to have to be improved for transporting the sick as well as transporting the patients or people for outpatient care.

Senator CLARK. Yes.

Dr. FICKEL. But I think the satellite concept with a central unit is going to prove to be very successful. We see that we—we see many bright points in the program.

Senator CLARK. Well, now, then, as I understand the way you are explaining this, we just take your own example here. You are saying that what you could do is take a community like this—and how big is Red Oak?

Dr. FICKEL. Red Oak is 6,500.

Senator CLARK. 6,500, and you establish a kind of center there, and in that center you have got 3 or 4 doctors who are working together out of that, or really in that center, and in the meantime you have gone out to these other communities, or some other communities. In this case you are right now in Malvern, and you set up a small family-care center there, and you have doctors that go out there on a part-time basis. In the meantime you have a full-time physician extender and/or physician's assistant or nurse practitioner, you actually had in that case?

Dr. FICKEL. Yes.

Senator CLARK. So that you have this center and you have satellites around here served by those 3, in this case 4 physicians, and the physician's extender that provides a whole area, and in this case 30,000 people, 30,000 rural people for health care.

Dr. FICKEL. Yes, another important ingredient, of course, is we have specialists available. We have surgeons available. These specialists are going to have residents available to service the local hospitals.

Senator CLARK. Now, you say that gives a lot better quality of health care than simply having one physician in each of these communities, if we had enough to go around even, which obviously we don't have. Is that your—

Dr. FICKEL. I firmly believe that.

Senator CLARK. That's really what you are saying in terms of your desire to go to a community like Red Oak and have that kind of arrangement?

Dr. ARTERHOLT. Yes, I strongly believe that, too, an isolated solo physician, it is almost an impossible job for him to keep up, to administer quality care over the years, which is what a community wants.

Dr. FICKEL. I have practiced in both situations. Even though I was in the same size town, I was a single solo general practitioner, and the quality of care that I gave my patients and the self-satisfaction from it is improved by this association with this type of practice.

Senator CLARK. It's clear to you that the quality of the care of the patient is significantly improved?

Dr. FICKEL. Significantly improved, and we are setting up a record system so that we will be able to measure that improvement, and improve it.

Senator CLARK. Additionally, I understand it gives you an opportunity to leave town and go have some education, some additional education? To go to conferences and to get a break from it in a sense, and at the same time have somebody back there to serve your patients.

Now, why do communities like Malvern have great problems in attracting physicians who will practice full time, simply because of this isolation, you believe, and the inability to really provide the things that they are going to need, both professionally and privately? Maybe I should ask you, is that a fair summary then?

Dr. ARTERHOLT. I think that's a fair summary, immediate medical education, resident education is geared today for a comprehensive

medical care. A resident coming out of a residency looks at a small community and has to evaluate it a lot more on technical medical grounds than perhaps the community understands. Will he be able to provide the quality of care that he would like to and chances are the answer is no in that situation. He's been trained to use a hospital. He's been trained to use a type of medical records which were—you asked me to talk about finances. They aren't cheap to set up. It isn't cheap to set up the type of office where we can do everything. We would have to have—if I was going to go solo, I would have to have approximately the same amount of equipment in my office as we have in our group office.

Senator CLARK. Yes.

Dr. ARTERHOLT. Which serves all four of us.

Senator CLARK. Well, now, I see the economics.

Dr. FICKEL. The presence of the hospital and Bill alluded to the matter of the comprehensive care, a family practitioner delivers babies, takes care of people with coronaries, does a degree of surgery, a number of things that are inhospital care. They can take care of diabetics who are severely ill. If you are isolated from your hospital and they are simply doing a hospital emergency room type of practice in the office, then this is totally unsatisfying.

Senator CLARK. Now, let me ask you just a followup on that. If we take for the moment the idea that you are promoting here I must say it makes a lot of sense to me. In other words, that you have three or four doctors grouped together for economic efficiency and for professional purposes, working together here with satellites out here that have full-time physician extenders, physician's assistants and so forth. Now, the question is how do we get those started around the State of Iowa? You have obviously done it now in Red Oak. Some others have apparently done it. We are going to be looking at others in some other parts of the State this week. Still we have an enormous shortage of physicians, I assume, and centers of that kind out in rural areas?

Dr. FICKEL. Yes, we do.

Senator CLARK. How do we attract people?

Dr. FICKEL. The residency training program in Iowa in family practice is going to be a supply of physicians trained in the diverse areas of the State. That's going to help enormously, and the number of men coming out of those programs is escalating at a very rapid rate. We will need the availability of more well-trained practitioners. We need—

Senator CLARK. You say well-trained practitioners, is that a general practitioner or what's the right term?

Dr. FICKEL. What I'm thinking of are the family practice nurse practitioners and the physician extenders.

Senator CLARK. Obviously we need well-trained physicians.

Dr. FICKEL. But for the extenders, they need to come out of good programs and have preceptorships under good physicians, so we need a great availability of those persons, the physician extenders, and also a great patient acceptance of what they can do and do well, because they do a very fine job within the limits of what they can do.

Senator CLARK. Right; you see a good part of the answer, at least a significant part of the answer to this is not just bringing physicians into this kind of setting that we are talking about today,

but also having the physician extenders, the physician assistants, and the nurse practitioners out there full time.

Dr. FICKEL. I believe it is a key role as long as their role is incorporated with the physicians.

Senator CLARK. Yes.

Dr. FICKEL. I would hate to see programs that are sometimes suggested—and we—in some areas, I think in Appalachia, this takes place and also in eastern Tennessee, where there is a traveling nurse practitioner who takes off into the hills and comes back out 3 weeks later. This is better than no care at all, but I would not like to see that in Iowa.

Senator CLARK. What about the public health care nurses?

Dr. FICKEL. Public health care nurses fit into it very well and they do a great deal of home care, but they do not really—they are not physician extenders.

Senator CLARK. Yes.

Dr. FICKEL. They provide a nursing service which is different in—I won't get into the length of time it takes to explain, but that's a different role. That is public health nursing. They are very important and we need more of them.

Senator CLARK. Are the counties supporting them adequately? I don't mean this county, but are counties in the State supporting them adequately to do a good enough job?

Dr. FICKEL. I think that many counties, the nursing personnel are not adequately supported, because they are advised that after the 3 year Federal program of funding is over that then they are going to be out of—they are not going to put any county funds in. Fortunately they do such a good job and there is such a need that the citizenry supervises—

Senator CLARK. OK. Those are the kind of things we want to have answered. Anything either of you would like to add?

Dr. ARTERHOLT. I might add one comment. Your question, how do we get these things set up. One problem in setting up a satellite is again the cost. We—as much as we like to be idealistic and humanitarian, if we are going to solve the health care problem through private practice, through fee for services, it has to be equitable financially. We have received—part of the reason that we were able to start our satellite was that we do have a grant from the Kellogg Foundation.

Senator CLARK. Yes.

Dr. ARTERHOLT. To help us in seeing if this concept is going to work, to help us get started. I have a couple questions concerning about—I think we all do about the satellite concept, which we don't really have an answer yet. One is, is it financially equitable for a private practice to do this? We don't know yet.

Senator CLARK. Yes.

Dr. ARTERHOLT. Two, will patients in that community or any community accept the services of a well-trained qualified physician extender under the direction of a physician, or would they prefer to drive the 20 miles and see the physician?

Senator CLARK. Let me tell you. Let me try to answer that for you. Just in one brief experience. We had hearings the day before yesterday up in Grimes, and we went up to Madrid where they have a physician assistant, and his name is Rich Pustka. It is just excellent. I mean the community. He's so busy you can't believe it, and he lives in the

community and so forth. He's under the direction of two doctors in Boone, and in terms of at least community acceptance there is just no question. If anything, I think he's overworked. He's had so much acceptance, and it seems that at least in their case, it is just working extremely well. One problem it seems to me, and I'm lobbying a little on this, but one of the reasons that we wanted to have these hearings was to try to get some testimony on the question of whether or not we should not in fact be reimbursing these physician extenders, physician assistants, practitioners under medicaid and medicare.

Dr. FICKEL. I think we can make a flat statement from the physician's point of view that it is absolutely weird to me that part of the Federal Government is so eager to provide improved care and backs a program, whereas another part of the Federal Government says we won't reimburse for their services when they are operating within the law. This makes no sense. They set up— They— The whole system sets up a structure of physician extenders, and then they can't get paid for what they provide, and one of the areas where their best service is in the area of care of the elderly, in nursing homes, in home care centers, and in isolated rural areas as well as in the cities for extenders, and they should be reimbursed. It makes no sense to me.

Senator CLARK. That's good. We are going to be quoting you now next year because I think that's the place that it is at right now. I mean we have got to do that. We are just not going to have health extenders if we don't change that regulation, if we don't in fact make it a part of the law. Thank you.

Dr. FICKEL. It also indicates that they are second rate health, and they are not, they are first class.

Senator CLARK. Thank you very much. I might say, by the way, that I notice Donna Slater of Congressman Harkin's office is here, and he serves on the House Agriculture Committee. We are glad to have her here. There are several types of material, by the way, back on the table in the back room, pamphlets on Federal rural health care programs and other pamphlets of interest. If people would like them, we are going to take about a 3 or 4 minute break here now to attend to some other matters. This will be just 3 or 4 minutes, and then we are going on with the second panel. Dr. Floyd Jones and Lavern Patterson and Phyllis Dobbs, and we are going to look at another example here of the Shenandoah Clinic and the Essex satellite, I guess you would say. So we are just going to take a break here for about 3 or 4 minutes, and then we are going to come back and have the other panel, and then we will have questions.

[A recess was taken.]

Senator CLARK. Well, now, let's have the next panel. We have got Floyd Jones, Lavern Patterson, and Phyllis Dobbs. Well, now, according to the list I have we are going to hear first from Dr. Jones, and then Lavern Patterson, and then Phyllis Dobbs, but you are welcome to start in any way you like, and maybe prepared, but just proceed. I think what we will try to do, if we can, is just ask each of you to speak for maybe 5 minutes, let's say a limit of 10 or less, whatever you are prepared for, whatever you like, and then we will have plenty of time for questions and discussion. So Dr. Jones, you want to start?

STATEMENT OF FLOYD ARDEN JONES, M.D., SHENANDOAH
MEDICAL CLINIC, SHENANDOAH, IOWA

Dr. JONES. I'd love to start.

I enjoyed the comments made by Dr. Fickel and Dr. Artherholt, and certainly many problems that we all share. I'm from Shenandoah, Iowa, and we have a satellite clinic in Essex community, also, about 6,500. We've had six physicians leave our community since 1971, three men, which had been there for over 20 years, and five men that have come to the community since then. We've had five total new physicians. I've been there for 4 years and we have a new associate at this time. There are various reasons for the men leaving. The last man that left was 27, and he related to me that he thought the demand on a family practitioner in a community such as Shenandoah was too demanding and certainly one of the reasons why he decided to leave, to get into a different field.

Many of the comments I'm going to make today are going to arise from the advisory committee of the rural care program which this information was released from the University of Iowa, College of Medicine in October of 1974. You have already referred to this project and there were a number of communities within the State that became involved with this, hoping to get State assistance or at least direction into models of primary medical care. I think the thing that they pointed out to us most is that the social economic trend that influences the growth and development of Iowa communities has had a tremendous amount of effect on the distribution of family physicians and accessibility to primary medical services. In the rural areas of Iowa such services as a result are often inadequate in supply and consequently they only began by traveling long distances or waiting extended periods or both in many cases. I think the majors that have been used to increase the number of practicing family physicians, numbers alone, medical volume, will not in itself solve the health problems of rural Iowa. I think studies evidently from the University of Iowa indicated that there was a broad trend for physicians to leave the rural areas which show reluctance to locate there due to the awareness of physician shortages and the overall workload that they have to maintain.

The University of Iowa indicated—our primary medical care program indicated that attempts to use—attract family physicians to rural areas by such means as educational loans, income guarantees, elaborate facilities, just don't fit the bill. You get these type of inducements anywhere. If you can get into a group, a large group, I think certainly without working yourself to death, you'd probably do so. They indicated to us, and I certainly agree, and I'm not going to elaborate at all, that the attraction seems to be most important into attracting and keeping physicians with close association with others in the medical profession, shared responsibility of night call, outpatient and emergency room coverage, vacation relief.

It is terrible to feel guilty your entire vacation because you don't know how the other patients are being cared for. Relief of continuing medical education and adequate time for family and leisure pursuits, and arrangements for specialty consultations which many of our areas are lacking. Also, of course, the financial benefits associated

with corporate and good practice which Dr. Fickel and Dr. Artherholt referred to. I'm not sure their study agrees with your map. We were told, and I certainly intend to agree that the critical areas in the State for physician shortage were in southwest and south-central Iowa and according to studies the attrition rate in these areas through the 1980's and up to that time will continue to be a faster rate than in the rest of the State, and I suppose this has to do with the fact that maybe we have an older physician population.

Senator CLARK. I wouldn't be surprised that what you say is not true because if you watch the demographics of the southwest part of the State, particularly southwest central to southwest, you see that happening in almost all of the area, sort of from here right up through here [indicating]. That tends to be the greatest problem area in terms of a lot of different economic factors.

Dr. JONES. I think that one of the things that is interesting, and I'm happy to see the lake across southern Iowa because many of the men want their recreation close to their communities. That's the only way to enjoy it, and one of the big drawbacks, if you are not a hunter in southwest Iowa is there's not a large body of water or other recreational facilities available.

Senator CLARK. We keep saying, you know, we are going to do something about Lake Manawa, but so far we haven't accomplished that.

Dr. JONES. I hope we can.

Senator CLARK. All right.

Dr. JONES. I'll leave that up to you.

I think it is essential, however, that the Federal Government get involved in the severe manpower shortage, and I think the Government must get involved. I feel that, as I said a few minutes ago, just increasing the number of physicians probably won't make too much difference. We'll get some more people, but I feel that at least in my training at the Osteopathic School in Des Moines and most of the medical schools, this is probably a true statement, that you are oriented toward university and large hospital medicine, and I'm afraid if we turn out more physicians without some other direction, whether it is a change in our principal teaching of medical students, that we are just going to have more family practitioners for the city and we will be sitting here with the same number in southwest Iowa.

Recruiting physicians, then, is a—and helping on manpower is critical to our needs and it is just—it's a very simple problem. We just don't have enough physicians for the people that we need to see. I think that in Shenandoah if someone is acutely or critically ill, they are seen immediately. Unfortunately there are other people that might not be so acutely ill that do have to wait at times for extended periods. I think we need financial—financing and Federal support to help develop satellite clinics. The clinics that I'm associated with in my group had no such help, but I think that many of the communities in Iowa would have to have it. Many of our elderly moved to communities of two or three to eight hundred people, and because taxes are less, living and expenses are increased, and the funds aren't available for many of them to support or to at least establish the initial clinic.

Senator CLARK. Let me say, by the way, just to interrupt you a second, that we were successful in getting an amendment passed that provided low-interest, long-term loans to communities to build or rebuild or modernize a clinic, a satellite clinic. Now, frankly, the amendment that I had passed had some grant money in it, too, but they dropped that in the House of Representatives. Is that the kind of thing that you think might be helpful in terms of startup costs or is that not the problem?

Dr. JONES. I think that would be very helpful in some cases. I think there are probably structures within most of these small towns that are more than adequate for clinics. Some of them are old homes, and if the money were made available to refurbish these homes or an old building on Main Street, it would be a great help, and I think on the long-term loans, low interest, that most communities would be able to support, you know, them alone. Financial aid to medical students is essential, and I'm sure that all my colleagues wouldn't agree to this, but I find it very reasonable that we tack on a requirement such as the Berry plan, that if you receive Federal moneys that you might be obligated by the country, the Government, to spend 2 years, 3 years in a rural area that has no physician or acute physician manpower problem. It is interesting, I think, many of the men that come who take preceptorships or spend time in the field with physicians often come back.

This is what we have been told has been the case in our experience, or at least relocate in an area similar to the community that they practiced in. With respect to preceptors, I think many of these men when they come where there was a real physician shortage and a need might be induced to stay and might want to stay. The last thing that I just want to mention briefly is that I think we need the Federal help, State help, any help we can get in expanding programs for physician extenders, nurse practitioners, physician assistants. We had been most happy with our program in Essex and our community I think is pleased. Essex is 8 miles from Shenandoah which is not a long distance. It is a community with a number of elderly people; however, the people there would see a doctor if they could find a ride to Shenandoah or Red Oak or whatever, and we are seeing these people now as they need to be seen. We lost our physician's assistant, recently we rehired a young man.

Senator CLARK. Oh, you did.

Dr. JONES. Starting in November and who will live in the community.

Senator CLARK. This will be what, a physician's assistant?

Dr. JONES. Yes, physician's assistant, so we are eager to have him back, and then have the clinic open full time. There are a number—or there will be starting next week four physicians rotating through Essex clinic for half days. Our new partner, myself, Dr. Gee, and Dr. Miller, who is a surgeon at Shenandoah—we feel a physician's assistant there who will live in the community and keep the office open with visits 4 days weekly, that we will be able to provide excellent service, and to again reiterate there is no decrease in the quality of primary care. These people are able to relieve the physicians in numbers of people that he has to see so that he may spend more of his time, and the time that he deservedly needs to spend on more severely ill people.

Senator CLARK. Thank you. I'm just going to ask you one question at this point. Do you think that satellite clinics, these programs can work if we don't start reimbursing physician's assistants, let's call them, under medicare and medicaid?

Dr. JONES. Well, there's no way that they can survive in my opinion. It's ludicrous that one part of the Government encourages these programs and other portions of the Government, including State government, do not pay these people. Unfortunately with expenses involved in running satellite clinics, physician's assistants and nurse practitioners are highly skilled people. They demand and should and deserve high wages or salaries, whichever, and with the expense of reestablishing a whole new clinic outside of the one that you have. If there's no reimbursement for the services it will go under because it's been a financial failure.

Senator CLARK. We can't really plan on going ahead with the satellite program if we are not going to reimburse under medicare and medicaid a physician's assistant?

Dr. JONES. I don't see how. I think this is the thing that has to be done and because a community such as Essex, Malvern, have gone to great sacrifices to build these clinics themselves. In Essex the case is to remodel completely and collect large sums of money, and I think we owe it to these people to let them know whether or not their clinics are going to be able to remain established.

Senator CLARK. All right. Well, let's hope we can get it done. Now, the next person I've got on the list here is Lavern Patterson, a banker in Essex, who has been active in community affairs. I'm hopeful you are going to tell us a little bit about how you got this clinic and what it means, if anything, to the community of Essex and so forth, but you proceed in any way you are prepared or would like to.

STATEMENT OF LAVERN O. PATTERSON, CHAIRMAN, MEDICAL COMMITTEE, ESSEX MEDICAL CLINIC, ESSEX, IOWA

Mr. PATTERSON. First of all we started out working with Roger Tracy in making an application trying to get a doctor to come to Essex. Of course, this we knew. This is an impossibility and highly doubtful.

Senator CLARK. How large is Essex?

Mr. PATTERSON. Community of 900. But first of all, you got to realize we are in between an area or triangle of larger communities of Red Oak, Shenandoah and nearby Clarinda, and we are approximately equal distance in time to get to any of these communities. And logically, a year ago, we thought if all communities could work together and set up a regional hospital down in Essex why everybody would be happy, but you got community pride and other facts. It's not going to happen, so we go on to the next best factor, and that's to try to establish a connection of obtaining a doctor, and, of course, this isn't going to happen if you are going to have to support three hospitals in the surrounding county.

Now, the next thing that when Red Oak was able to secure this grant and also to be appointed as the recipient of a medical facility fund, we met with some people from the University of Iowa and said,

well, what else can be done, and they came back with this program, practically immediately that we had acted upon whether or not we would be willing to accept the services of the satellite system, medical care, with the aid of physician's extender or a licensed nurse to serve in this area, also, and we said absolutely and we will go to take the steps that we will try to get a suitable clinic built, an office facility available. And we have an organization within our commercial club or chamber of commerce, and we have a small community, and we took this program on by ourselves and went out in the community and raised approximately \$30,000 to refurbish and rebuild an existing structure with contributions from the community. Donations were no higher than \$250 all the way down to \$5, whatever anybody would like to contribute.

Senator CLARK. So it was all contributed, \$30,000?

Mr. PATTERSON. Well, our total cost in doing this, we went through and practically got our building, putting in four examining rooms, two doctor's offices, a lounge, a reception area, records, and emergency medical area. This whole concept like anything else you start out with something that is going to cost you \$25,000 and ends up costing another 15, but the idea was and still is that this is an area of social economic allegiance, I guess you'd say, to the community of Shenandoah because this is where most of our trading area goes and we have a large number of people that would go to Red Oak, but we are kind of in between and we felt, and I think it is something that must be considered, your community—outside community must pretty well build where the trade is concerned. And in our community we felt that—also that if we are going to do this program and become involved in it, let's do it right. Don't spend all kinds of money on it because we assessed the program insofar as buying a package of a new building, a new facility outside of town, which would cost well in excess of \$100,000. Well, we were raising this among our community members and immediately you've got initial support of everybody that's got a buck in that clinic. So if your personnel are qualified there's no reason they're not going to support it, and this has been the case. The quality of health care that the people in—and our nurse practitioner has left us, but in regard to her medical qualifications, there was no question regarding her abilities.

Senator CLARK. Your fundraising is an interesting idea. I never thought of that. In other words, if they gave you \$1, \$5, or \$50, they are more apt to support it, I suppose, aren't they?

Mr. PATTERSON. Well, we found this to be true, and we have a large number of people that—well, there are people that still seek their family physician in Red Oak, which is fine, but they still contribute toward this goal, and we haven't yet, I don't think we ever will say all right this is in Essex, you support it, because we haven't tried to sell to anybody. OK. We are going to break off your relationship with your family physicians and this is not our intent, and we hope that in the future we can get a better working relationship so that the doctors in Shenandoah, Clarinda, Red Oak, or Omaha would be able to rely upon the services of this medical standard or physician's standard as it is. I don't know if I have any other questions.

Senator CLARK. I'll have a number of questions, I'm sure. So we'll go right on and talk to Phyllis Dobbs. I know you live in Essex,

Phyllis, and I'd be particularly interested in any reactions that you might have to having the clinic there and what it means. Just anything you'd like to visit with us about with relation to that clinic.

STATEMENT OF PHYLLIS ANN DOBBS, ESSEX, IOWA

Mrs. DOBBS. Well, actually, I'm just a housewife and mother, and I do live in Essex. I was one of those selfish people that had our family doctor, and I didn't think about anybody else. If they had theirs, fine. If they didn't, well, you know, that's tough. Then mine left, and so we went to all the surrounding towns looking for a doctor that we felt comfortable with. If you've ever traveled 15, 20 miles with a small child alone while they throw up, it's not good. You need something closer. Or say their eyes are rolling back in their head. I mean I don't know what is going on. You need something closer. It's scary, and we have primarily a bedroom town, and we have elderly people there in the daytime and we have young mothers with small children, and that's almost all we have. Mothers don't—that don't have children are usually working and so this is—and so we needed a lot of help. It was frustrating and it was scary. It was just scary not to have anything close, and I think the clinic is perfect. I wish that every town that was in our situation had one.

Senator CLARK. If you didn't have that clinic, what difference would it make?

Mrs. DOBBS. Well, I go to the clinic more than I would go to the doctor.

Senator CLARK. I see.

Mrs. DOBBS. Consequently, I take my children more often because, you know, before you ever call the doctor he's busy, and he's busy with important serious things, so you wait. Let's see if it is going to get serious enough to call the doctor, you know. And so consequently you have kind of a guideline to follow. When the temperature hits 103 then we go, you know.

Senator CLARK. Might be waiting too long?

Mrs. DOBBS. Yes, and it takes them longer to get—well, because you waited too long and a lot of things could be prevented, and I know that since the clinic has been there, and I don't even hesitate to call if I don't know about it. I call, and we go. And another reason that you hesitate to call the doctor is it's going to take you time to go down there, time to get back, and time to sit and wait. All right. If you have more than one child, one child in school, you take the other one down there, then this child's going to come home from school, and even if you go at 2 o'clock in the afternoon maybe you are not going to be back in time, and here is this child coming home and nobody there; where there isn't the waiting at the clinic, and if it is something serious that the nurse practitioner can't take care of she sends you immediately to Shenandoah and you are treated as an emergency patient, and you don't have to wait.

Senator CLARK. You know you are a very young woman, but I would think people who are in their seventies, let's say, or early eighties might well go there. They wouldn't get in the car or couldn't get in the car, or get somebody to drive them there. It seems to me that would be a particularly important factor in a clinic of this kind—older people

who really cannot get around who need health care, but perhaps not so terribly sick that they are going to call an ambulance.

Mrs. DOBBS. That's right. What about the ones that need a shot every week. Most of them are maybe on social security. They can't afford to call a cab. Maybe they don't have any children around, and what's going to happen. I mean, they have to have this shot every week. Well, if it is in Essex, a neighbor will run them down, they can walk, you know. If they are mobile they can walk down there. Essex is not that big a town. I'm sure that the elderly people in our town get a lot better care now than they use to get because they did without things that they really needed.

Senator CLARK. One out of every five who lives in Essex—you come from a big city, you are from 900 and what?

Mrs. DOBBS. About 900.

Senator CLARK. I come from a town of about 490, but the thing I was wondering was what other kind of medical services do you have there? I mean do you have a dentist or any other kind of health services at all?

Mrs. DOBBS. No. We have a few registered nurses, and usually if a kid cuts his leg you run him over to one of them and say is this bad enough that I should take him down and have him sewed up. I mean—and we used our nurses in town for advice, and, of course, they couldn't treat us but for advice should we go on down to the doctor.

Senator CLARK. Do you have any idea what people there would do for mental health problems? Is there a center in the county?

Mrs. DOBBS. Clarinda.

Senator CLARK. Yes, of course, Clarinda.

Mrs. DOBBS. And I think that's one reason that when they make these surveys about how many physicians we have in the county it comes out looking like we have got more than we have.

Senator CLARK. Yes, but they are over at the Mental Health Institute there, not spread around, that's a good point.

Mrs. DOBBS. It makes us look like we are in better shape than what we really are. I like the idea of a nurse practitioner or a doctor's assistant at the clinic for several reasons. If the doctor has to come up, it is not taking any pressure off of him. In fact it probably is adding more because he has his travel time, and you cannot arrange your illness to fall on Monday, Wednesday and Fridays, so you still end up having to go to another town even though you do have a satellite clinic there. And I'm another one of these awful wicked people that likes to see the same person over and over. I wouldn't like socialized medicine where you are put in a cubicle and you don't know who's going to walk in and take care of you. I like to see the same person, and I think it is probably selfish, but if they know things about you that aren't on that chart well that's the way I want it. In fact, maybe they don't even have anything to do with your medical history, per se. They know she is a nervous person and she will get hysterical at the least little thing, and her son just left for college so she's going to blow up all her illnesses out of proportion. They know these things about you.

Senator CLARK. You'd like to be able to go back and see the same person, at least the same one or two or three people?

Mrs. DOBBS. Yes. I want them to at least be familiar with me, my life, my family, I think almost everybody would. I mean it is an ideal situation, and if we couldn't have it we could do without, but that's what we like.

Senator CLARK. Yes.

Mrs. DOBBS. And having a nurse practitioner or a doctor's assistant at a clinic right there in town, somebody with small children, and I don't want to make cracks about the elderly, but they do tend to get back there a little bit like small children and if they know this person socially they see them at the ball games, at school programs, at church, there's not this fear of going to them. A lot of kids are scared of the doctor, but they see these people even when they are not sick, so then this removes the stigma from the nurse practitioner or doctor's assistant. She's just not the bogeyman that gives you the shot every time. You see her at the ball game, yelling just like you are, so they are not so afraid.

Another thing with them being in the same community as you are, for some reason or another, small children think that if they don't do what they tell them to they will know it, you know. They are in close proximity and they will know it, and so that helps the mothers quite a bit.

From an educational standpoint they are great. They have the time, they are not overworked. They can give talks. Ours gave talks to 4-H girls, expectant mothers, things like this. I don't know whether it is because they are in the community and you do see them a lot, or whether it is that you know they don't have quite as much education as the doctor, but you'll ask them questions that you probably wouldn't ask the doctor because it would make you look dumb, you know, and they will answer. And, of course, the doctor would, too, but you don't want to appear that ignorant to the doctor so you ask them.

Senator CLARK. You are probably right. You shouldn't be, but you are probably right.

Mrs. DOBBS. I know I am because I know from experience. The things that they teach these kids and the expectant mothers and everything like that isn't anything probably they couldn't find in a library or something like that, but it's more real when they tell them about it, and maybe they've got questions they wouldn't know where to look for.

Senator CLARK. I haven't thought that much about that point, toward health education and prevention.

Mrs. DOBBS. Yes, a lot, and if even it wasn't for these talks and films and things like that, I still feel that it is a preventative medicine because you will—like I say, you will go to her first. I mean quick where you hesitate to bother the doctor there, and so that's sort of preventative medicine, too. I know that our clinic is firmly established because some of the most hardcore diehard nonbelievers like my father now go to the clinic.

Senator CLARK. That was one of the things I was going to ask you, how well the nurse practitioner is really accepted. Were people really prepared to go to her? Did they think, "well she isn't a doctor, I don't want to?"

Mrs. DOBBS. It took awhile. Some of us that got to know her right at first, there was no hesitation at all. She's a very professional person and there was no hesitation, but it took awhile for some of them. To quote my father, "I wouldn't let her bandage up a cut finger for me." But now he goes there quite regularly and is very impressed. I don't know, I guess they have to see other people doing it. It has to be proved, but ours is a firm group. I'm sure of that. The feeling that we get—that I get and I know a lot of my friends get from that clinic being there is a feeling of security that we've just never had before.

Senator CLARK. Well, you are a good witness to this clinic, obviously. One of the best we've ever had. It sounds like it is working very well. Now, let me ask you just a couple of questions. You think that the community of Essex is now reasonably satisfied with the level and the quality of the health services that are being provided by that clinic?

Mrs. DOBBS. Very much. Very much.

Senator CLARK. They have accepted it. They think they are getting good care. And now, I guess at this point let me ask Dr. Jones. Maybe you went through this, but I don't remember it exactly. What kind of direct physician's care do you have in Essex?

Dr. JONES. In Essex we have a physician going up for half-day periods, 4 days a week. It had been 3 days a week. Now it will be 4 days a week, then I think it is important too that people aren't charged doubly, I'd like to mention that, for services. I think it would be an easy thing to have happen. If someone is seen in the Essex Clinic and they have to be seen by the doctor who was sent to the Shenandoah Clinic again there is no charge for that service and they are treated as an emergency and seen immediately. I think this aids the physician a great deal in having qualified persons on the scene to evaluate the people that need to be seen like this, and also aids us in getting to them quicker.

Senator CLARK. Do you see any particular thing that we ought to be doing at a Federal level that we are not doing now? You responded already in the terms of the medicare-medicaid thing. Do you think of other things that this committee or that the Congress ought to be considering or ought to be doing or ought to be looking at more closely in terms of what we could be doing?

Dr. JONES. Well, I do think that there must be ways, whether it is through loans that many medical students need to get through medical school, it is very expensive, schooling to go through; and I think possibly through Federal loans that we could induce people to spend at least 2 to 3 years in their rural area. As much as we use to induce people—not induce them. If they joined the Berry plan they went into the service when they finished their training, and I think we should apply the same thing to our rural areas in physician manpower problems. The other thing I see, and I probably am overlooking it, but that is I think possibly that Essex is an unusual community. There are communities within our immediate area that I don't believe would have the resources to do as much as Essex did, and I think that we ought to have funds available as we talked about earlier, loans of low interest and so on that might be available to help the community establish a—

Senator CLARK. Now, just generally speaking, do you agree with Dr. Fickel and Dr. Artherholt that the answer, or at least a good part of the answer, to rural health care is this system of establishing a central clinic of a few people, maybe two, maybe three, maybe four doctors working together, and then the satellite program with physician's extenders or physician's assistants out in those areas, is that the pattern that you see as being most apt to satisfy the health needs of this country and this State?

Dr. JONES. Yes, I do, and I feel it is an excellent approach and probably the only approach that we—due to the factors that we mentioned before, isolation, physician becomes antiquated rapidly if he doesn't continue his medical education. The need for consultation, professional association and so on. It is just a real detriment to encourage anybody into a small community by himself. In this manner we can have quality people giving good primary care extending the arms of the physician, and with the extension, the physician making weekly visits to the clinic enables him to insure the quality of the medicine is what is planned to be.

Senator CLARK. Let me ask Mr. Patterson. We are very interested in this whole problem of establishing clinics and how you do that. What some practical ways are and so forth, whether we ought to have a grant, and that kind of thing. I was wondering how many different people you recall offhand did contribute to that clinic?

Mr. PATTERSON. I'd have to say in general, and this is one of the things that I should have looked up because—I'm sure it would have been informational for your committee and all concerned, but we had a list of people in the community that we thought would be good prospects for this type of thing and those that might be selected to do this work or whatever.

Unfortunately we didn't have many \$1,000 givers, not many \$500 givers either, but that's not—but I think we did have approximately 200 people that did donate, maybe 250 families.

Senator CLARK. Really?

Mr. PATTERSON. But out of this may be only 90-some donated \$250, but this isn't the point. I think in order to establish a clinic, a satellite clinic of this type, what really needs to be done, whether or not they raise large sums of money or even come up with \$1,000 or \$2,000, first of all you need to have a commitment from the community.

Senator CLARK. That's right.

Mr. PATTERSON. It doesn't need to be large, but it needs to be—some at least to show their interest, and second, I think there needs to be not a large amount of grants or anything like this because this is still business, and it is a private enterprise type of operation, but we need to have funding available at a low-cost basis for a period of years. Similar to what the Farmers Home Administration is doing an outstanding job in several areas, and this is the organization as I see it that should be worked through to enable additional or increase the quality of health care through facilities.

Senator CLARK. I see. That's exactly what this amendment we passed 2 months ago will do. It doesn't give it to every community. It may be too strict a qualification. I'm not sure. You have to meet the criteria that is set up to get a doctor under the National Health Service Corps. In other words, you have to be truly needy to get it,

but we are hopeful that this might have some prospect for helping some communities. I think in some communities, I think other things satisfy their needs, and other cases it might be of some assistance.

Mr. PATTERSON. This program is economically feasible. It's—there's no reason it can't go on its own once those things are established, but here again it is just like when a person comes right out of college, they don't have enough money in their account to buy everything in the window, and so you got to take it a step at a time and work into it. You don't go out and buy \$50,000 homes when you are only earning a salary that's commensurate with mine of 20, and this is the same way with this type of program.

Senator CLARK. Well, it sounds like you have done an excellent job in Essex and you are very happy with it.

Mrs. DOBBS. Very.

Senator CLARK. I wish we had another hour to give people in the audience a chance to ask any questions and make any comments. We still got Dr. Fickel and Dr. Artherholt here if you want to ask questions and answer them.

Mrs. SAMUELSON. I would like to say something.

Senator CLARK. Yes; could you give your name and address so we can get it on the record? What is your name?

STATEMENT OF ROSEMARY SAMUELSON, COORDINATOR, CATHOLIC SOCIAL SERVICE AND AREA XIII AGENCY ON AGING, COUNCIL BLUFFS, IOWA

Mrs. SAMUELSON. Rosemary Samuelson. I work at Catholic Social Services in a home maintenance program for the elderly in four counties in southwest Iowa. My question is: Considering the rising cost of living and inflation, what does your office charge for your fee for an office call in your clinic compared to a private doctor, or could you tell me what exactly it is?

Dr. JONES. I can tell you what we did in Shenandoah, it is exactly the same.

Mrs. SAMUELSON. Which is?

Dr. JONES. Which is an \$8 office call in our office and the Essex office accepts whatever medicare pays, and we don't ask for any difference.

Mrs. SAMUELSON. Also along these same lines I was waiting for the subject to come up, but it didn't, and therefore I'd like to ask exactly what is the status of malpractice insurance? How does it relate to the rising cost of office calls, which is now \$10 in Council Bluffs, and could you clarify for me your point of view?

Dr. JONES. I'd like to talk all night on the price of malpractice insurance, but I don't think that's what you are interested in. I think you are interested in what it does to my malpractice insurance and what—

Mrs. SAMUELSON. And how that is reflected in the cost to patients.

Dr. JONES. I don't think it has any reflection in here in our case. Our nurse practitioner pays for her own malpractice insurance.

Mrs. SAMUELSON. Out of her salary?

Dr. JONES. And it cost her \$300,000 malpractice coverage at \$25 a year, and I pay \$25 and tacked it on to my policy and that covers her after the initial \$300,000. The \$300,000 for her cost \$176 a year.

Mrs. SAMUELSON. Then why do we hear about this continually in the media, and from the doctors, about the exorbitant cost of malpractice insurance?

Dr. JONES. Because there's a big difference between her malpractice insurance and my malpractice insurance.

Dr. FICKEL. Family nurse practitioners and physician's assistants are different, and let's not put this in the paper because it will probably go up 1,000 every night.

Mrs. SAMUELSON. But I have heard from other sources——

Dr. FICKEL. On physician's extenders they——

Mrs. SAMUELSON. But I——

Dr. FICKEL. He's giving you the rates on the doctors.

Mrs. SAMUELSON. I guess it's the rates of the doctors that I am making reference to. Are you saying the rising cost of malpractice insurance, is not causing the high cost of medical care?

Dr. FICKEL. On some groups in the States the cost has been as high as \$60,000 and \$70,000 a year premium for malpractice insurance in the State of Iowa.

Mrs. SAMUELSON. Could you tell me in the last year——

Dr. FICKEL. I would say this, if I may interrupt, we in medicine, and I think Dr. Jones will affirm this, have absorbed our increase in the cost of malpractice particularly with reference to medicare and medicaid reimbursement because they're back several years behind in establishing their levels of payment, so we have had to absorb the cost.

Senator CLARK. In other words, it is not possible to pass it on to them?

Dr. FICKEL. You cannot pass it on through these reimbursement programs.

Senator CLARK. Other questions?

STATEMENT OF FRANK KOWAL, DIRECTOR, IOWA WESTERN AREA XIII AGENCY ON AGING

Mr. KOWAL. Yes; Frank Kowal here, Iowa western area XIII Agency on Aging, director for eight counties in southwest Iowa. I think Dr. Fickel and the other gentlemen indicated that part of the satellite process would be equally dependent on availability or accessibility to transportation. I would hope through these hearings that there would be equal attention paid by the committee for encouraging the Federal Department of Transportation, specifically to recognize the operational cost factors for maintaining and developing transportation for the rural counties. At this juncture in Iowa particularly county boards of supervisors are frequently financially strapped, and I would agree with your earlier comments that many of them do not have an adequate tax base to pay for visiting nurses as well as other supplementary human services, so I think we are talking about just a part of the problem. It appears to me that the planning from this group needs to plan rural health clinics regionally into the most logistically accessible locations for serving concentrations of population throughout rural areas.

Senator CLARK. I think it is a good statement. The last time we were in this area we were here under the auspices of the Aging Com-

mittee in which we were looking at just that, how do we get transportation in rural areas and how does that tie into problems of nutrition and problems of health care and so forth. In talking earlier, I think with Dr. Artherholt down in Malvern, he was making the same point, and others have made that point, that transportation is a key part of this problem. How you are going to get those people into those clinics, and some cases even in the same small town it is a problem, and I think it does all tie together. In fact, the jurisdiction of this subcommittee really is just rural development, and it is all a part of that. It is the problem of the elderly, the transportation of elderly. It is medical health care of the elderly and some other things, but they are a very closely related thing.

Other comments or questions?

STATEMENT OF HAROLD C. SMITH, EXECUTIVE DIRECTOR, RIVER BLUFFS COMMUNITY MENTAL HEALTH CENTER, COUNCIL BLUFFS, IOWA

Mr. SMITH. I'm executive director of River Bluffs Community Mental Health Center, and I'd like to just express something that I think should be in the record, and that is that in addition to the reliance on the kind of private satellite clinics, which have been discussed today there is a role for the public health sector to provide the same kind of services from a centrally located public health clinic, such as a community mental health center and I would hope that this source of service delivery would be considered by the committee in any future legislation.

Senator CLARK. That's a good point. Could you expand on that in terms of what kind of services and so forth?

Mr. SMITH. I am actually just talking about the agency that I represent. We are a community mental health agency, and we serve both the urban and rural areas out of Council Bluffs. We presently serve the four river counties through satellite locations Oakland and Avoca in east Pottawattamie, Sidney, and Hamburg in Fremont County and Malvern and Glenwood in Mills County.

Senator CLARK. What kind of satellite operations are those? Is there a center there that's—

Mr. SMITH. This is one of the problems we do have. We don't actually have good facilities in most of the areas, and a lot of places we find ourselves with somewhat inadequate facilities. In east Pottawattamie at Oakland, we were in a doctor's office for awhile, now we are in a church in Glenwood, and in Malvern we rent office space. In Malvern we rent half a day's space in the local tax consultant's offices. In Hamburg we are in a church and in Sidney we are also in a church. In Harrison County we are in a church, in Missouri Valley we rent space where we use the churches. These facilities are not always adequate and I think in providing for the development of better health facilities this is one of the considerations for the committee to consider. I think in talking about health service delivery, I think there's a real need to have some sort of loan program, as you previously mentioned, to develop community based outpatient facilities that could be used not only by physicians but psychiatrists, psychologists, and so forth. There are advantages in mental health by having our services provided at such health facilities, with other

physician groups, because it removes some of the stigma and loss of confidentiality experienced when a facility is only identified with a mental health problem.

Senator CLARK. I think it sounds to me like it makes some sense.

Mr. SMITH. So I will wish that the Senate consider this.

Senator CLARK. Good. I appreciate having your comments. Dr. Artherholt, you had your hand up.

Dr. ARTERHOLT. I would like to respectfully disagree with something Dr. Jones said. In responding to your question about what else could the Federal Government do, I personally am strongly opposed to the Federal Government's saying that you will go here and practice for 2 or 3 or 4 years.

Senator CLARK. Even if you agreed to it as a basis of the scholarship?

Dr. ARTERHOLT. Yes; the reason is, you have to consider again quality of care, not just quantity. The problem, as I understand it, the way that this has been proposed, a medical student would take a year of internship, and then would owe his country 3 years in a deprived area. This doctor's interests may be in psychiatry or surgery or internal medicine or some subspecialty, and in this situation then we would go out into, let's say a rural Iowa area, being totally unprepared for family practice in a rural setting, having had no special training in this.

Senator CLARK. Now, I understand that problem, if you were specialized and you were sent out to do something else, but couldn't we limit the scholarships to general family practitioners? I don't mean all scholarships, but I mean these scholarships. I suppose the problem is then nobody would take them.

Dr. JONES. I think you are wrong. I think they would.

Senator CLARK. We better give you a rebuttal.

Dr. JONES. I think fellows would take them when they didn't want to go to the service, and sometimes you have to do something that's not just exactly what you would like in order to accomplish a goal and maybe make it easier for your family. I had available to me an obligation to make in the State of Iowa 10 years of my life if I wanted to have my loan forgiven, or if I wanted half of my loan forgiven I had to give the State of Iowa 5 years of my life in a rural community. I don't begrudge that at all. If I didn't want to do it I could have practiced for a few years and paid the loan back which isn't all that much then gone somewhere else.

I don't—I hope you don't develop a medical approach to medicine like Mexico has, but Mexico does this to their family physicians—or their physicians, they are obligated to spend, I don't know the length of time, in rural areas that deprive—are deprived of medical care, and most of them—I had a friend that graduated from the University of Mexico, and he feels that it was very bad regarding time—

Senator CLARK. Regarding time?

Dr. JONES. He wasn't really needed. He didn't stay.

Senator CLARK. What do you do about this problem that Dr. Artherholt is talking about? Suppose you are trained in a highly specialized area and maybe there isn't that much demand in Essex or Shenandoah?

Dr. JONES. I think that there's all kinds of possibilities like Bill said. It's absolutely true. Some subspecialist out practicing general medicine, it would be just as dangerous if I was forced to practice

the specialty, but I do think that within this whole concept we do need to develop regional centers where maybe groups can go, 30 miles to a specialty oriented clinic or something of this nature, or if maybe it would only work for family practitioners; I think a lot of thought would have to be put into something like that before it would work. In Red Oak and Shenandoah we have the 55 miles for most of our specialty consultation. We are lucky to have an internist in Red Oak that helps, and we have a general surgeon in town, but other than that we have to go some distance.

Senator CLARK. Let me say now again that we have these forms, for anybody who is here who would like to write anything down or take any home or mail them to us within a week for further comments about your own view. You don't have to be a physician, just anyone who has got some idea or points to make that they'd like to have in the record, and we will put them in the record as if presented here. We will take one more question.

**STATEMENT OF MARLIN J. STIRM, ADMINISTRATOR, CASS COUNTY
MEMORIAL HOSPITAL, ATLANTIC, IOWA**

Mr. STIRM. Marlin Stirm from Atlantic, and I would like to bring emphasis to some things that have been touched on about health care and public health.

Senator CLARK. Good.

Mr. STIRM. I think there's a great need for financing these types of programs, not only from the local county level but looking at it through medicare, Certified Home Care programs, we find in the program that I'm involved with that in many cases people that need services in their homes, nursing services, do not fit into the guidelines and therefore they have no funds under social security and thus they are denied the programs.

Senator CLARK. I know what you are speaking of.

Mr. STIRM. These programs could be preventative in nature. When people asked me how to get a handle on cost, I say simply by staying healthy. I think the homemaker aide program is an example. I think the program involved with meals on wheels is another example in our part of the county. That's one point, comprehensive home health care services. Another thing, we find that presently there are no ways of reimbursement for patients who need respiratory therapy services in their home or physical therapy services. You could go on and on, I think that if we wanted to encourage prevention and health, we should get behind these programs. OK. That's one point.

The other point is we've been talking primarily about physician recruitment. I think that it would be remiss to leave out the need in rural Iowa for dentists, registered nurses, licensed practical nurses, physical therapists, and pharmacists. Occupational and speech therapists are practically not available in many sections of rural Iowa, so I would like it entered on the record that I feel something should be done to encourage an increase of these types of personnel in our area.

Senator CLARK. Thank you very much. I must say I think you've made a lot of good points. We are looking here at sort of one aspect and we think a very important aspect, but as it is a broader problem,

and like all things they do tie together, and they are important particularly if you are talking about health maintenance and protection, and the kind of services you are talking about, home health care services, are obviously the very crux to this whole question. Whether you are talking about physician's care, extended care, everything we've talked about here is expensive, terribly expensive; and it means that if we are really serious about this, and I think people here are, that it is going to cost some money. It is a question, I suppose, of getting our priorities in order in our own country and being able to carefully spend the money that we need in these programs for people's own health and welfare. It is a tremendously expensive business.

I know the whole health and education and welfare area just in the 4 or 5 or 6 years that I've been involved in Government has gone up significantly, and yet we all know, anybody that is involved in it, that there are enormous unmet needs in the areas you are talking about. For example, I hope that we can get some kind of handle on other expenditures which we could agree upon are of less significance and put some more of our resources into these areas. It is very important.

Well, thanks to all of you for coming. I think it has been very valuable. I think the two examples in particular that we've seen here today seem to tell us at any rate that there is some hope for reversing this trend in the rural areas, and if we can produce the number of family practitioners, if we can get them out into rural areas, grouped as we've seen in this case, if we can establish the satellites. If we can establish the physician's assistants, get them reimbursed, if we can provide this kind of health care over a period of time, we can reverse a trend which I think is fairly apparent, not only in this State but all across the country, and provide equal health care for people in the rural areas.

Well, thank you for coming. The hearing is now in recess.

[Whereupon at 5 p.m., the subcommittee recessed to reconvene at 2 p.m., Sunday, October 17, 1976, in the American Legion Hall, Merville, Iowa.]

RURAL HEALTH SERVICES IN IOWA

SUNDAY, OCTOBER 17, 1976

U.S. SENATE,
SUBCOMMITTEE ON RURAL DEVELOPMENT
OF THE COMMITTEE ON AGRICULTURE AND FORESTRY,
Moville, Iowa.

The subcommittee met, pursuant to notice, at 2 p.m. in the American Legion Hall, Hon. Dick Clark (chairman of the subcommittee) presiding.

Present: Senator Clark.

STATEMENT OF HON. DICK CLARK, A U.S. SENATOR FROM IOWA— Resumed

Senator CLARK. The hearing will come to order. I would like to welcome you to the hearing of the U.S. Senate Subcommittee on Rural Development which is really a subcommittee of the Senate Committee on Agriculture and Forestry. This is one of a series of six hearings that we're holding. In fact, this is the third. We'll be holding hearings tomorrow over in eastern Iowa. We've held hearings in central Iowa, around the Des Moines area and out in Grimes and Madrid and that area; and then we have also been down in the Council Bluffs area, a community much this size, the community of Treynor. It's simply an attempt this month to investigate the rural health care problems in this State.

I'm pleased that some of you could join us on a Sunday afternoon. I believe that all of us can get a better understanding, if this hearing is anything like the ones that we've held before, of the unique problems of rural areas in terms of attracting health personnel and in terms of other kinds of health problems for small towns. The Iowa hearings and visits to health clinics are part of an ongoing effort of this subcommittee to study the problems of rural America generally, not just health problems. I mean, we're looking at all kinds of problems. That's the jurisdiction of this subcommittee. We're concentrating in this series of hearings on problems of health care, and we're trying to generally analyze current efforts to address this problem of rural development and to determine the proper and most effective future role of the Federal Government. Are we to have any role? If so, what should it be, what should it not be, by way of trying to develop a better health delivery system in the smallest communities.

Last February, I might say that Senator Leahy, who serves on the Senate Agriculture Rural Development Subcommittee with me, held a series of hearings on this same subject up in Vermont, going to small communities, talking to people about health care in that area.

There we learned about the special circumstances of those living in rural New England, and about some innovative grass-roots activities to deliver health care services to these people. One of the interesting things that we learned that has been confirmed also in our hearings here in Iowa, is that the attempts to attract health personnel to remote areas are often stymied by the archaic medicare reimbursement regulations; and we have found perhaps more and we will be talking about this today, or asking about it, really.

The problem is simply this, that if you have a nurse practitioner or a doctor's assistant, some nonphysician who is providing health care to older people—of course, we have a lot of older people in the rural communities—they are not reimbursed under medicare and medicaid. It makes it very, very difficult then to afford to have physician's assistants and nurse practitioners without having that reimbursement under medicare and medicaid. So that's been our No. 1 priority since the Vermont hearings. I must say we have failed so far to pass such legislation, but it will be the highest priority as we go back, I'm sure, from these hearings as well.

We also learned in those hearings that communities needed financial assistance in some cases and some stages for establishing a primary care clinic out into the smallest communities; in other words, just the money to start to get a building, to construct a building or more often to renovate a building to bring the facilities for a rural clinic or a satellite clinic in a small town. We did pass successfully an amendment which I offered 2 months ago in the Senate, now a law which provides communities of this size and others, with low-interest long-term loans to establish rural health care clinics. So those were two of the things that came out of our Vermont hearings that we think are important; and that's really the kind of things that we are looking for here: what works, what are the problems, first of all, what is the nature of the problems of getting rural health care services to small communities, and what are some of the things that we might be able to do to correct that?

Now we're in Iowa this month to assess the special needs that we may have here in this State. Next year the subcommittee is going to conduct similar hearings in Appalachia and in several of the southern States. We want to make this a national investigation. Our emphasis this week and last week, of course, are in Iowa. Now our goal is to return to Washington then with some concrete proposals to fulfill the promise of providing adequate health care services to all Americans, whether they live in the affluent suburbs or in the most rural areas of this country.

Obviously, we all pay taxes on the same basis, and we're interested in trying to receive health care to the very best of our ability and the same kind of equality. This objective can never be accomplished without the help of people who have some knowledge of this problem right here in the smaller communities, and that's why we have the witnesses whom we have here today, people who have worked in that environment who are concerned themselves and directly involved in providing health care or in trying to get health care to their community. We're trying to do this, in effect, out in the field, rather than simply holding another hearing in Washington, where people have relatively little direct acquaintance with the unique problems of rural America.

So we're here basically to listen, to try to hear from those who have a direct and intimate knowledge of the problems of rural areas, and people who have tried to solve that problem. I might just say that our Nation has spent millions of dollars, really hundreds of millions of dollars, in the past few years to encourage health professionals to practice in medically underserved areas. We've tried almost every imaginable carrot approach to try to get more physicians to come out into rural areas and into underserved areas generally. But this effort, quite frankly, has not been very successful, as evidenced by the statistics; and therefore health personnel are still clustered primarily in urban and suburban areas. Without new Federal initiatives, based on our experiences in States like Iowa, the geographic maldistribution may well continue.

Now, I'm not suggesting for a moment, by the way, that I think there is something magic about a county line or a city limit and somehow we all ought to have exactly the same number of doctors. That's not a practical approach at all. But it does mean that one way or another, through clinics and satellites or something, we have to be able to provide emergency and basic health care everywhere to people who live everywhere, and in some practical way to at least provide services at some location that is reasonably close enough to give something approaching equal service.

Let me just go to a couple of statistics with that thought in the back of our minds. We're not talking about, obviously, having a doctor in every single community or a hospital in every community or having exactly the same number in the same counties; but it gives you some broad picture, when you hear the statistics, of the nature of the problem. And Iowa is no exception, really, to other States in the Union in this regard. In fact, we have addressed ourselves to the problem a little more quickly than other States.

While the country, as a whole, has 130 general care physicians per 100,000 people, Iowa has only 55 rather than 130 to every 100,000 people. Now, that's about 1 general practitioner for every 2,000 people in the State. It's a very, very high ratio. The national average, for example, is about 1 to every 760. Or let's round it off, 1 to about every 750. Our average is 1 to 2,000, again principally because we are in a rural area.

If you look at the statistics, from the highest communities, that is, the most populous communities to the least populous communities, you see a direct ratio there of physicians in this country. For example, let's take the very top. If you look at communities of 5 million or more, the doctor-patient ratio is 511 to 1, in other words, about 500 patients per physician. If you look at the United States as a whole in communities of 10,000, the ratio is 2,500 to 1. That means that if you're a physician in a rural area, you tend to serve on the average five times as many patients as you do if you live in a very large city. That's the problem in a nutshell.

It's just the question of getting enough people in some practical way. We know in Iowa, for example, right now that half of all our physicians live in just 6 of the 99 counties. Half of all our physicians in just 6 of the 99 counties. So it's a real problem. I might say, incidentally, to make matters worse, one out of every three physicians in our State are over the age of 60, so that we're entering a period

where we are going to have difficulty, if we can really convince a lot of people in the medical profession to go into family practitioner courses and come into rural areas, we have a lot of difficulty just keeping up with those who are leaving without making any great progress. So that's the nature of the problem. The question is, how do we solve it?

I see I've got a couple of figures here also that I might just mention about northwest Iowa, where there are some particular health manpower problems. The National Health Service Corps, the Federal program which places young doctors in rural areas, has determined, for example, that Lyon and Ida Counties have particularly critical medical shortages. All counties, except Dickinson, Buena Vista, and Emmett, are considered by the Department of Health, Education, and Welfare to contain medically underserved areas. Or another study, the Iowa Health Manpower Plan of 1975. Now, this, of course, was determined by people in this State in the medical health manpower profession. They concluded that three counties, Lyon, Clay, and Monona, have the most severe problems in northwest Iowa and less than three-fifths of the current need for general care physicians are being met in those three counties.

Well, one can see the nature of the problem. The question is, what do we do about it and what, if anything, is the Federal role? What's the State role? What is the community role? How do we make this Federal system of Government work, in other words, State, Federal and local government working together? And that's what we are here about, to try to hear some examples of the nature of the problem from various people that are going to be witnesses today, and to talk to some people that have looked at that problem and have, to some degree, at any rate, succeeded in trying to address themselves to it. So we are very pleased to have two panels here today, really. We are going to hear first from Howard Logan and then from Dr. Hamm, and then from Don Smutzer. We're going to hear from all three of you for whatever time you want to take, hopefully 5, 10 minutes, something like that.

Then we're going to have questions. Then we'll have a second panel of Dr. Zoutendam, a physician up at the Sheldon Clinic, and then also from Jack Myers, physician's assistant at the Sheldon Clinic, and Vennetta Fiedler, who is active in Spencer in terms of health care there. We're going to have six witnesses, three on a panel, then three on a panel later, and then at the end we'll open it up for any comments or questions or anything anybody who is present might wish to make.

I might say also that we have a form here in which anyone who may not have time to speak or would like to say something about this subject, can fill it out and mail it to me. I see we even have self-addressed envelopes here. Mail it back to me, and we'll put it in the record here with the court reporter as if presented. So we want to give everybody an opportunity to say anything that they may have to say about this subject. Well, I've talked too long already, so let's just go ahead. We'll hear from each of the three witnesses about anything they have prepared to talk about, and then I'd like to ask some questions, probably.

First, Howard Logan, who is a banker and has been particularly interested in this whole question of health care here in Merville.

Perhaps he'll tell us something about his experience and what exists here and what the problems are, that kind of thing. Howard, you go right ahead any way you think appropriate.

STATEMENT OF HOWARD M. LOGAN, MOVILLE CHAMBER OF COMMERCE, MOVILLE, IOWA

Mr. LOGAN. Thank you, Senator Clark. We here in Movable have been interested in getting a medical doctor since we last lost the services of our previous doctor in 1962. At that time, the Movable Chamber of Commerce determined that we should appoint a committee, an ongoing committee to attract a new doctor to Movable. I don't believe we even had one at Kingsley at that time, did we? Was Dr. Powell up there at that time?

Dr. HAMM. He came in 1959.

Mr. LOGAN. In 1959. At our bank, we had noticed that in 1959 we helped finance that clinic building up there for Dr. Powell, and in a very, very short time that was completely paid for, so we felt that in Movable we had just as good an opportunity for financial progress of a doctor as they did in Kingsley. And so we went off actively to get a medical doctor.

But we found that this was very difficult. We contacted the Iowa Medical Society. We put ads in newspapers. We contacted returning Vietnamese war doctors, veterans. We raised funds through the Movable Community Development Association to fly doctors here. We entertained them in our homes. We contacted doctors from Ireland, Great Britain, South America, just all over the world, trying to get someone here. We entertained in the wintertime, in the summertime, in Omaha, in Sioux City. Every place that we could find an interest, we were very active with our committee for a period of about 12 years.

Through this 12 years or through the opening part of this period, we felt that we should have a clinic building such as the legislation that you have recently passed, so that we could have facilities for a doctor to come in. However, we didn't know what type of building we should build, because the medical profession was changing very rapidly. So we went out in the community and raised pledges for \$43,000 at that time, which was considered adequate for a good office building for a doctor. Our close proximity to Sioux City and their hospital system, we felt that there was no need to have hospital facilities in Movable; but if we could have a good clinic building, why, this might attract a doctor.

According to a newspaper clipping that I have from 1965, there were 209 individual subscribers who pledged a minimum of a hundred dollars, and that \$42,800 was pledged. Even with this pledge, we could not attract a doctor. Mainly, small towns were not considered as great a social attraction, I felt, for their family as they are today.

Since 1968, however, we did attract a very fine young dentist, and so we have excellent dental service at this time. The clinic north of us at Kingsley has given very good general practice coverage to our community, and the emotional issue of emergency service was removed when we raised the funds to get a rural ambulance service. Before that time, why, we could envision a crash, a heart attack or something

like that. It was going to be a major emotional drain on our community. But now with our rural ambulance service that need seems to be met in the minds of most of our people here.

Senator CLARK. You do have a good ambulance service?

Mr. LOGAN. We do. It's on a volunteer basis. It's through the Menville Fire Department; and we have 15 or 16 rather young men who staff that, and they've done an excellent job.

Senator CLARK. Are they well trained in the problems of emergency care?

Mr. LOGAN. Yes; they're very eager about this. I just can't do anything but commend them for all of the time that they spend every week, and they have excellent equipment and facilities. This was always on a volunteer basis, also, this money for the ambulance service.

Senator CLARK. And they have been trained?

Mr. LOGAN. They have been trained, yes. So now it appears that our greatest need, in order to have a doctor, a family practice doctor here in Menville, I would feel would be to have more of them. And with the new family practice residency in Sioux City being established in just the last year, we're hopeful that some of these young doctors will get acquainted with the territory and decide to move into family practice in this area.

Now, it looks to me like the practical thing to do would be to encourage them to go in and practice with someone like Dr. Powell and Dr. Hamm as kind of a satellite office in another community, if that's possible. Then they can cover each other's practice during weekends or holidays or something like that, and you wouldn't have the drain on the time of the individual doctors that was the objection.

I think that your clinic-building financing bill sounds very attractive. I would also like to have you perhaps consider—and maybe legislation has been passed—for the Farmer's Home Administration or some similar agency to finance on a long-term basis—low interest rates if possible—nursing homes which, built in communities of this nature, then could provide a basis for a family practice doctor to come into our community. So these are the two suggestions I have.

Senator CLARK. Good, excellent. I've got a number of questions of you, but I think maybe we'll just listen to the other two and then try to get all three of you involved, because I think it's clear that you're all related to the same question. I mean, all three witnesses are not only related to the same subject of rural health care, but also related to the same area. So let's just go on and hear Dr. Hamm, who is, of course, a physician up at the Kingsley Clinic.

Just out of curiosity, what is the—I guess I could look on the map here—but what is the population of Kingsley and what's the population of Menville?

Dr. HAMM. The population of Kingsley is 1,100, and I think it's about the same.

Senator CLARK. About the same? Okay, so it's a good comparison in terms of size.

STATEMENT OF CHARLES HAMM, M.D., KINGSLEY, IOWA

Dr. HAMM. Well, I've been thinking. I was going back over this, what motivated me to come to a small town, and I really don't know,

other than the fact that I grew up in a rural area and always had a real desire to come back to this. And in thinking over some of the discussions that we had when I was in school and during the internship, some of the things that tended to make people shy away from an area, a rural area such as this, was the fact of the difficulty of maintaining a hospital practice with this much distance involved, and of course, without hospital facilities. Certain emergency facilities, this kind of thing, are not as readily available. But I've seen over the years that the communities in this area have done a really good job of overcoming some of this; and what Howard touched on is a matter of a good, well-trained emergency medical crew in each community.

Moville has done, I think, an outstanding job on this, and the other towns surrounding Kingsley have an ambulance with a trained crew. Pierson, Correctionville, Anthon, these towns have all accepted the responsibility in providing this, and this has been a real help to us in the total health care, making it possible for patients to be safely transported to the hospital in any one of the areas that we serve, and this has been a real help to us over the years. Another of the things that I think is going to be—I hope will be helpful, because I certainly sense that there is a real shortage just in our own area, even though there are two physicians in Kingsley; still, we recognize the plight of the surrounding communities and realize that our own limitations, as far as extending the type of care that each community should have, I'm hoping that the residency program which is now in use in Sioux City and is attracting some real fine primary care candidates, I'm hoping that this will attract people to the rural area.

Part of their program will be to spend some time working in rural clinics, hopefully our own and perhaps some of the others in the area. I think the only way to convince people that rural practice is not a frightful thing, but really a very good life, is to expose them to it and help them to perhaps overcome some of the fears and apprehensions they might have of being this way, this far away from the shelter and protection of the hospital environment.

A couple of ways in which a physician can be helped to extend his services. One is through the physician's assistant, and we have been fortunate to have Don with us. He came for his internship this summer and has stayed on now as part of our health care program and clinic in Kingsley, and I think one of the things that was touched upon—I believe you mentioned this, that you have been trying to get this changed—is medicare and medicaid reimbursement. And this is a real problem, not only for the physician's assistant, but also for the nurse practitioners or home health care programs which would be possibly even set up out of a clinic office whereby there would be a little better continuity of patient care.

Now, we have several agencies: the county health nurses, visiting nurse associations, and some of these. They do provide care for a number of our patients, and I think they do a fine job, medication checks, blood pressure checks, just to see that all is well. And this is very reassuring to these people, and I think this could be perhaps extended. Again, if it were done through clinics, allowing medicare and medicaid reimbursement would make this feasible, because most of the people that we would be reaching through this type of program would be elderly people.

But I do feel there are couples and individuals who could be kept out of nursing homes for at least some period of time if there was someone just to drop in on them regularly, assist them with their medication and helping them to deal with their health, nutrition, and this kind of thing. And I realize this is being done to some extent, but I think this is an area where some additional recognition of the need would be helpful.

One of the things that has come up, that you mentioned in your letter or invitation, are any additional programs or Federal financing of health services. I think the programs that are existing at this point, at least, appear to be adequate, if they could be made a little less cumbersome. Sometimes it's really difficult to know for sure what type of care one is going to be able to give and expect the program to support it.

Senator CLARK. Except for the medicare, medicaid. You would like to see that extended to the physicians and assistants?

Dr. HAMM. Yes, yes. This, I think would be helpful, because actually in the long run, I think this would be a savings, because nursing homes are not inexpensive.

Senator CLARK. That's right.

Dr. HAMM. And if people can be kept independent, there is no better environment than a home environment for an elderly person, and I feel very strongly about this. And anything we can do to extend their time there and postpone the time of commitment to a nursing home, I think, is not only to their benefit but also economically we'd be ahead, even if it would require regular visits by a nurse or attendant of some kind. I have been concerned a little bit—I know Howard mentioned this, the willingness of the Merville community to provide funding for a building, and you mentioned that this is being considered in a Federal program, and I think back to when the Sears Foundation had this. I don't know if you recall. This has been some years ago.

Senator CLARK. Yes.

Dr. HAMM. I don't know if they're still doing that. And they would serve a community which would request this, and if they felt it was indicated, they would go ahead and help with the financing of the clinic building; and this sounded great at that time, and maybe they'd get a physician for a few years. Maybe they couldn't get any at all; and a lot of these buildings are sitting empty and being used for something else. I think if a physician is motivated enough to go into a community and accept the responsibility for his own—at least, a good share of his own building, maybe some assistance with loans and this kind of thing but I think the more involved he becomes in it, the more apt is he to stay on and become a part of that community; and I think this is something important to consider. I think that's it.

Senator CLARK. Good, fine. We'll be coming back to you. I want to particularly go back into some of the thinking, as you remember it in your case or others that you talked to, as to why physicians in particular—other reasons that physicians, to go back into something you mentioned, might be less or more reluctant to come into smaller communities as compared to Sioux City or Kansas City or Chicago or some other place.

Well, let's go now to Don Smutzer, who is a physician's assistant in the Kingsley Clinic. One of the things I've become convinced of in a series of these hearings, rightly or wrongly, is that the physician's assistants are going to be crucial to this whole question of addressing ourselves successfully to the problems of rural service. So, Don, I hope you can tell us about what a physician's assistant is, what you do, how you are able, in effect, to extend the physician out into the community effectively.

**STATEMENT OF DONALD F. SMUTZER, JR., PHYSICIAN'S ASSISTANT,
KINGSLEY CLINIC, KINGSLEY, IOWA**

Mr. SMUTZER. Thank you, Senator Clark. First of all, a physician's assistant is not a doctor. He is someone who is trained to give some of the health care that would normally be given by a doctor. In my own case, I was a registered nurse first specializing in emergency medicine. I decided to go into the physician's assistant program because there was a shortage of doctors available at night, and this was when I primarily worked. The physician's assistant training program that I went to was Kettering Medical Center in Dayton, Ohio. There I was trained to attend to routine medical problems, and care has pretty much been protocolized. In other words, I have talked with physicians and learned what they would do in similar situations, and the care that I give is approved by them.

I have been trained to assist with surgery, to perform very minor office surgeries, to care for minor fractures, to repair lacerations and that type of thing. As you mentioned before, medicare does not reimburse physician's assistants for what they do. In the case of the Kingsley Clinic, their practice includes quite a few nursing home patients. I think there I could be more valuable to my employers if I could see these people. House calls is another area that could be a problem with medicare patients. A physician's assistant naturally would have more time and would be able to do some of these things. Dr. Hamm mentioned follow-up care for elderly people. I think this would be a terrific program. Many times people come to the office, and maybe they're not quite sure of how they're supposed to take care of something at home. If someone could go to their home and actually do this for them and show them how it should be done, this person could then evaluate whether or not they are treating this problem themselves in their home effectively. I think that this service could really be invaluable.

The ambulance service has been mentioned here, too. I think that this area is really fortunate in the ambulance care that is available. Having worked in a hospital in Sioux City where the ambulances are manned by professional people who work in hospitals, and then comparing it to the ambulance service in Dayton, Ohio, for example, where the ambulances are manned by volunteers, there is just no comparison. In this area, the volunteers really care for each patient, because they know everybody. In Ohio, most of the volunteers are people who are just interested in the excitement of going with the red light and siren. The ambulance service out there is atrocious. I was very glad to get out of that area with my family. Here, even though the ambulances are manned by volunteers, the difference, I think, is the fact that these people care. So I think that the ambulance service here is great.

This basically is all that I have to say. I'm a relative newcomer here, so I don't really know all of the problems of this area. But I will be happy to answer any questions.

Senator CLARK. Okay, let's go to the questions. I wanted to just kind of get the geographic and, I guess, demographic factors down here on the record to start with, and maybe this, Howard, is something any of you can pitch in on, but this is something perhaps that you could particularly address yourself to. How far are you actually from the closest doctors and hospital in Sioux City?

Mr. LOGAN. Our closest doctors, of course, are Kingsley.

Senator CLARK. Yes. I meant in Sioux City, though.

Mr. LOGAN. But in Sioux City, to the city limits we're 14 miles.

Senator CLARK. How far would it be to the hospital?

Mr. LOGAN. I'd say to the hospital 3 additional miles; 16, 17 miles.

Senator CLARK. 16 or 17 miles, and it's what, 9 miles to Kingsley?

Mr. LOGAN. Yes.

Senator CLARK. Now, is there a hospital in Kingsley?

Mr. LOGAN. No, but there is a nursing home there.

Senator CLARK. Nursing home.

Mr. LOGAN. And a good number of Merville—formerly Merville residents now reside in the Kingsley Nursing Home.

Senator CLARK. And you have no nursing home in Merville?

Mr. LOGAN. No; we don't.

Senator CLARK. And really, the only hospitals that are accessible then are in Sioux City, aren't they?

Mr. LOGAN. Yes.

Senator CLARK. That's the only practical one. And Dr. Hamm, your hospital is Sioux City?

Dr. HAMM. (Nodding head affirmatively.)

Senator CLARK. And both communities are about 1,100, and there are really no other communities, even of that size, in the area until you get to LeMars or Cherokee or Storm Lake, except for Sioux City; is that right?

Mr. LOGAN. That's correct.

Senator CLARK. That's about it. Do you have any idea what the percentage of people over 65 would be in Merville or Kingsley?

Mr. LOGAN. In 1963, there was a medical-economic survey. I don't know how these things have changed.

Senator CLARK. Probably not a great deal.

Mr. LOGAN. It says 9 percent of the population is over 60; 26 percent is between 40 and 59; and 46 percent is under 21.

Senator CLARK. It's probably gone up a little.

Mr. LOGAN. I think so.

Senator CLARK. Because the average in Iowa now is a little—I think it's about 12.3 percent are over 65. We have the second or third largest, depending on whose statistics you believe. It's always interested me that that was the case; I've never been quite sure why. But Florida, I think, has the largest and Iowa traditionally has had the second largest. I guess Arkansas has just moved into second, and we're third now, according to the latest statistics. I don't know why that's true, but we also know very clearly from census studies that a disproportionate number of these older people live in the smallest communities.

And of course, we also know that older people tend to have—and all of us, as we get older, tend to have more medical problems for good, logical reasons. You have been searching here for a doctor in Menville for what, 12 years, actively searching for 12 years?

Mr. LOGAN. Yeah, 12 years.

Senator CLARK. I've got sort of, I think, the geographic picture and the nature of the population and so forth. Obviously, it wouldn't seem that there is anything wrong with the town in terms of attracting the physician. I mean, you have been actively working, organized to try to do that and so forth, so there must be some logical reasons, or at least some reasons about why people do not, in fact, come to Menville.

I might say, Menville is not unique. We have been going around all over the State hearing almost exactly the same kind of story in community after community after community. What do you think, though, before we go into that, Howard? What do you see as the major problem or the reason why these doctors—you brought them here. They listened to you, as you say. "We," what did you say, "wined them and dined them" or whatever?

Mr. LOGAN. We certainly did. We even sent a bottle of Piper Heidsieck to one of them. [Laughter.]

Senator CLARK. I see. And even that didn't convince them, so why not? What did they say? What kind of feedback did you get or what do you think?

Mr. LOGAN. Well, originally the small town was out of favor, particularly with the doctors. The history was that the doctor was on call 24 hours a day, 7 days a week, and no one wanted to be a slave to their constituents that much, like a Senator is now. [Laughter.]

Senator CLARK. I know what you mean.

Mr. LOGAN. And so particularly then. On the other hand, a good many of these doctors have been exposed to the cities, the hospital facilities. They like that, and their wives didn't want to come to the rural communities. We didn't have the social background that a quote "doctor's wife" felt was up to her standards at that time. And just recently, the last 4 or 5 years, all of a sudden the rural areas are the place to come and they have been, these people, have been coming out of even a city as small as Sioux City. They have been coming into the country, building their homes, because they want to know where their children are going to school and they want to know the people that are involved with educating their children, and the safety factors of the rural areas. So now we are popular again.

We really think we're on the edge of a breakthrough, as far as having a G.P. medical doctor here in Menville. We haven't got anyone in mind. We're hoping that maybe Dr. Powell and Dr. Hamm can get someone to associate with them, or perhaps some new doctor will come into Anthon, or perhaps from this residency program in Sioux City. This is our biggest hope, that a group of Sioux City physicians will determine that they could pull in additional business if they had someone representing their group out in an office in Menville.

Senator CLARK. Now, the emergency care, though, has really helped your community a good deal in terms of heart attacks and accidents and that kind of thing, hasn't it?

Mr. LOGAN. It certainly has. As I say, it took the emotional thing out of this, the fact that we don't have a doctor.

Senator CLARK. What do you do, though, aside from emergencies, if people get sick, then? It's fairly obvious, I guess, but I'd like to be sure for the record.

Mr. LOGAN. Well, as I say, our primary general practitioners are the firm of Powell and Hamm in Kingsley.

Senator CLARK. So most people here would just get in the car and go up to Kingsley?

Mr. LOGAN. Yes. Now, we have a new service, a minibus service set up. I think it's through the Health, Education, and Welfare.

Senator CLARK. Yes, the Aging Agency.

Mr. LOGAN. Yes. The people who need this type of service and the older group are served by it. This transportation facility helps.

Senator CLARK. And then the others, the ones that don't go to Kingsley, would go to what, Sioux City?

Mr. LOGAN. They go to Sioux City.

Senator CLARK. Various doctors?

Mr. LOGAN. There are some general practitioners. Myself, I go to the specialist. Whatever is wrong with me, I go to the specialist.

Senator CLARK. Now, interestingly enough, just asking the question, perhaps Dr. Hamm is the one to ask it of, but I was walking in Sioux City yesterday afternoon last evening, and someone stopped me and said, "I see you're holding these rural health care hearings. What about Sioux City? We don't think we have enough physicians, either." Is there a shortage of physicians in Sioux City as well?

Dr. HAMM. Yes. We take our rotation providing emergency coverage at the hospitals in Sioux City, and I'm really surprised at the number of really fine people who have to use the emergency facility because they have called every office, every resource, and they're just not able to get in to be seen; and we even have some of those people coming out to Kingsley, because there is no way they can.

Senator CLARK. It's interesting.

Dr. HAMM. And there is, I would say, an acute shortage in Sioux City.

Senator CLARK. So we say that it's not just the small community, either, in this case, although in most cases in Iowa—and I'm saying something here I'm not all that sure of—but I think in most communities of Iowa of 100,000 or more, by comparison with the rest of the State, there do seem to be enough physicians, do there not? Is Sioux City unique in that regard, do you think?

Dr. HAMM. Well, I think as far as the speciality coverage, of course, the specialists are all quite busy there, too. But I would say primary care is where Sioux City is really the shortest.

Senator CLARK. I see. Well, I want to ask you now, Dr. Hamm, some questions almost in an attempt to answer Howard Logan's problem if we can. I think you have stated the problem. It's just very clear. Here we are. You've worked very hard to try to get a physician. They've got, I don't know, I think there are now on file something like 160 communities in the State not all in exactly your situation, but they're all looking for a physician. I've got a map here that shows northwest and western Iowa communities requiring physicians. This is a University of Iowa tabulation. It lists all of them right here and

so forth, got red on the map just to show this part of the State. You could show the same thing everyplace else.

So the problem's pretty clear. Now, the question then becomes, why don't physicians come into the Movilles of this State and this country? And you have addressed yourself to some degree to that, I think, Dr. Hamm, but I would like to go into it in a little more detail. First, I'm basing these questions really on the other hearings I've heard, and doctors' talk about why they didn't, and you have touched on some of those.

What about this whole problem of professional isolation? I keep hearing that. Almost every physician that I talk to says, well, in the old days it's quite true, before the war particularly, that a doctor was a physician, was willing to, in effect, because they were required to, operate out of the black bag in a sense. They lived in each of the small communities. I live in a community of about 490, the little community of Lamont. We had a doctor until 1946 or something like that, and have never had a doctor since, obviously. The major reason is professional isolation. There is no other doctor to consult with, no hospital facility close enough, no other kind of emergency facilities that are adequate and close enough. Is that a major reason or not, as you talk to doctors or in your own experience?

Dr. HAMM. Well, I'm sure for some that is a major reason, but in our locality, at least, I don't think this is particularly or wouldn't necessarily have to be a valid reason. When Dr. Powell came to Kingsley, he was alone for a few years and he had ready access to the men in Sioux City, some of the specialists. If he had a problem, he would have no problem in calling them, consulting with them either by phone or taking a patient in or whatever. Since I moved to Kingsley, I have many times realized the importance of having someone to work with, because sometimes just talking over a problem or something—

Senator CLARK. Exactly.

Dr. HAMM [continuing]. This is real important. And I've often felt how, even if I were in a surrounding town practicing by myself, there would be a certain isolation there.

Senator CLARK. Do you think you'd do it if you were all alone?

Dr. HAMM. I'd be very reluctant to go alone in a community where I didn't have a relationship with somebody. Now, if I were 10 or 15 miles from somebody that I could get acquainted with, could have confidence that he would cover my patients and I'd be willing to cover his patients, so that there would be some free weekends, this kind of thing, I don't think it would be quite too frightening then. But for someone getting right out of a residency program where they have had people all around them to answer all their questions right on the spot, I suppose this would be a little frightening.

Senator CLARK. I think that's the other thing. You see somebody just coming out—and I must say you may be unique in your willingness to come out and work, even in a community like Kingsley that does not itself have a hospital, because the other witnesses that we have had before this committee—Red Oak is a good example. We had a hearing down in Treynor a couple days ago. We have the clinic at Red Oak, which has done some very excellent things, and the doctors there, for example, testified that they can conceivably attract doctors

there where the hospital is right there. You have got immediate emergency and other kinds of quality, I suppose you'd say, care immediately at their hands, in a sense. And they consider that an enormous advantage.

And therefore, if you assume that there are few enough physicians, then one can go, for all intents and purposes, where they want to go. In other words, making a living is not a problem for a physician. It's a problem of doing it in the way in which you feel you could do it best and most adequately and so forth. Therefore, if there is not a hospital there, it's much, much more difficult to get a physician to go to that area. Do you think that's generally true? Of course, you're only how many miles from the hospital?

Dr. HAMM. Twenty-five miles.

Senator CLARK. But even there, it can be in terms of having it immediately accessible. You're at somewhat of a disadvantage.

Dr. HAMM. Well, this is why we're really fortunate to have the emergency care in the communities that we do. This takes a lot of the pressure off of us, because if there is a crisis in a community, we don't have to drop everything and go running down, because we know that these people will have safe transport into the hospital where emergency care is available. And this has become really a fine thing.

Senator CLARK. And, as you say, this joint consultation. Now, there are two of you, aren't there?

Dr. HAMM. Right.

Senator CLARK. And we have had several physicians there who have said, well, you know, it makes a great difference if you're out in a community alone and you see some rash or anything, and you don't know for sure what it is. If you can call over immediately in the next room somewhere, you know, very close and call somebody in and say, "What is this, now? What do you think?" and get in consultation and so forth, and particularly in diagnosis, that it's an enormous advantage in terms of attracting a physician to that community.

They're reluctant to want to go out there on a solo and do it. So it may be that if you're going to attract someone, you will have to attract two, at least. Howard?

Mr. LOGAN. We found that out, Senator, that even two or three or four, if you could get a couple of specialists and maybe a dentist in the same building and build this clinic that we were planning on building, we were hoping to have a group come in.

Senator CLARK. But, you see, how do we really do that when you look at all those spots? I mean, we might settle Menville's problem, if you're really aggressive and go out and get them and so forth. But then we have 160 others; and that means if each has three physicians, let's say, we have got to have 450.

According to our statistics, even though we are really emphasizing family practice in this State that it would be something like 1990 before we can just replace those that are already leaving without increasing any at all from 1976 to 1990. Now, hopefully those statistics are wrong, but how do we do it?

Mr. LOGAN. We need to educate more doctors.

Senator CLARK. Maybe that's it.

Mr. LOGAN. Build more medical schools out in the rural areas so that they're familiar with our area, and then the economics of the

thing. When they start starving in the cities, they'll come out here where they can make \$50,000 a year, and we'll have our doctors.

Senator CLARK. Well, let's get back here a little closer to the real world. The other testimony we have had from physicians, young physicians who had just come out—these are mostly people who have come out to rural areas, too—is that if you go out into a solo practice in particular, that you immediately have a lot of problems.

No. 1, you have got nobody to cover your patients, so that you can't possibly easily or responsibly go on vacation. You can't leave for a weekend. You can't go someplace else for a night. You can't go to medical conventions and keep up your profession and so forth. So that again, there is this requirement, if you possibly can, get two or three to cover.

The other interesting thing is that I have found in these hearings that people say, "Well, gee, we have got plenty of work out here. There are plenty of sick people. A doctor's not going to have any problem coming to our community being busy and making a living." And the response, again, that we have got from physicians—and I'm interested in your response to this—is that that's the problem, that people don't want to go where they're going to be just absolutely worked to death in about 30 years. Do you think that's a logical conclusion or not?

Dr. HAMM. Yes, I think so. If I were—well, I think a physician, like anyone else, is entitled to enjoy his family and something other than just his own little world of medicine. And I suppose for that reason I would have been reluctant to go into an area alone. Even Dr. Powell, when he came to Kingsley, had a medical student who was a year or two behind him who was at least tentatively planning to come to Kingsley, so there would be two.

He was there alone for a year. Then he had someone with him for a couple years, and then he was alone again for a year. And then I moved there. So it was with the thought that he would not be alone to cover that area, because that gets rather overwhelming.

Senator CLARK. Now, what about this question that Howard brought up a couple of times? What about the problem of social—or maybe we could say, social and cultural isolation? I suppose that there are people that say, "Well, I want to live—" Maybe they're athletic fans. They want to live where there is a professional athletic team or college team, or maybe they want to have access to a library or the theater or whatever they happen to be interested in. Is that a real problem of the doctor and his wife, do you think?

Dr. HAMM. Well, for us it wasn't. Of course, having grown up on the farm, graduating from a very small high school, it was no problem for me. My wife was born and raised in Omaha, so it was a bit of an adjustment for her. But it was a pleasant adjustment, and I don't know how to overcome that. To me it's been no hardship.

If we want to take it—and, of course, we can do this with two of us being there—but if we want to take a weekend, if there is something special going on in Omaha or somewhere, we're really within a pretty good distance to just about any social or cultural activities that one maybe would want to participate in.

Senator CLARK. But a new physician, maybe, who is coming out who hasn't had that experience, might not view it that way.

Dr. HAMM. That's right. And he might feel that he's isolated. His wife might feel terribly isolated, and this could be—

Senator CLARK. Just lastly now, before I turn to Don, what about even the financial and the professional advancement? I mean, wouldn't some young physicians look out and say, "Well? I don't want to go to Lamont," where I live, "or Kingsley or Merville, because frankly I'd probably make more money in the suburbs in Chicago or Des Moines or someplace than I can there, even though I could make a very good living there, clearly." Isn't it really true that, financially, doctors make more money in the large suburban centers?

Dr. HAMM. Well, that's very true, but I think, I guess, this becomes a little bit philosophical.

Senator CLARK. Yes.

Dr. HAMM. What are your values? What's really important? I think a physician could make a comfortable living in any one of these rural communities. It's how much gravy do you want on top of what you really need, I suppose, and how much are you willing to pay for it; because to me, it would be a very sorry thing to practice suburban medicine, because I have a lot of respect for the people in these communities and we have what I think is a good relationship and a mutual trust that one just doesn't have in—and I just don't know how to overcome this in physician candidates, other than exposing them through their training program and helping them to see that rural practice is the way to go.

Senator CLARK. Well, now, let's talk to Don. And I'd like to have the other two of you pitch in here at any point, because really, I want to look lastly at what do we do. We've seen some of the reasons why physicians may not want to come to rural areas. We have seen the experience of Merville doing everything it conceivably can to try to do it; and the question I put to all of you, and really to Don first, I think, is just sort of one solution that we might find in this in which the physician's assistant is crucial.

If we can't get doctors to come out in solo practice in each of these communities, 160 communities in Iowa, if the numbers are just not there in the next 10 or 15 or 20 years, how about the idea of establishing these group practices like you have done in Kingsley, perhaps in many cases even in larger communities, if that's necessary, communities, let's say even of 5,000 to 10,000. They've done it in Red Oak, for example, of having these central group practices and then establishing clinics, satellite clinics, let's call them, out into as many of the other communities as we possibly can, having those manned with physician's assistants like Don here, or nurse practitioners, and then having physicians go to these communities like Merville, let's say, on a part-time basis but having an absolutely full-time physician's assistant on duty who lives in that community all the time, and constantly under the very direct supervision of the physician; and as I say, the physicians themselves attending there as often as they can and doing this in relation to a hospital. Is that a possible solution from your point of view, Don?

Mr. SMUTZER. Well, I think, Senator Clark, that this is one of the reasons the physician's assistant concept was developed. However, there are a lot of States that have State legislation that really prohibits this, and I understand Iowa is one of the States.

Senator CLARK. That prohibits what?

Mr. SMUTZER. I understand that in Iowa, the physician's assistant literally has to work under the same roof as the physician.

Senator CLARK. Well, now, some of them are not. I think they're working under very direct supervision. For example, we visited the clinic in Madrid, which is a community of 2,500, who has never been able to attract a physician and does not have a hospital, but does have a full-time physician's assistant who works very directly with the two doctors in group practice in Boone. Again, he's the full-time person in that clinic and very, very directly under the physicians' supervision. I saw their phone bill, for example. They're in constant communication, but they're not really in the same building, you see.

So I think our law will at least allow that. We've got several of them doing it. The problem, of course, is getting reimbursed under medicare and medicaid for doing it, and so forth. There are some real economic problems associated with it, but legally we could do it. But do you think that that could be, assuming the legalities of it are not a problem, do you think that can be a part of the answer to extending health care on down into small communities?

Mr. SMUTZER. Yes, I think it could be a very real answer to some of the problems.

Senator CLARK. Now, you're able to do, as a physician's assistant, a number of things quite directly. You mentioned some of them. Could you repeat those? What kinds of things could you do that makes it possible there for the doctor to do more advanced kinds of things?

Mr. SMUTZER. Well, for example, if someone comes in with a laceration, I can repair that, provided there are no tendons or any major damage done underlying the skin. I have been trained to care for minor fractures, to apply casts.

Senator CLARK. How about something like blood pressure, taking blood pressures?

Mr. SMUTZER. That's one of the very elementary things that I was trained to do.

Senator CLARK. So if we had a physician's assistant, let's just say for the time being, in Merville under the direction of Dr. Hamm and so forth, you provide that? You could provide some basic care?

Mr. SMUTZER. Right.

Senator CLARK. And emergency care?

Mr. SMUTZER. Right.

Senator CLARK. And you can give shots, I assume?

Mr. SMUTZER. Yes.

Senator CLARK. Anything of that kind. That seems like a practical direction to go, if we're not able to provide enough physicians; is that an understatement?

Mr. SMUTZER. I think that is a very real possibility.

Senator CLARK. Wouldn't you, though, have the same kind of reluctance, maybe, to go to a smaller community without there being a physician there, as a physician would?

Mr. SMUTZER. Well, my original goal was to be a country doctor. By the time I got ready to go back to school, I was too old to get into medical school. So really, as far as I'm concerned, that wouldn't really be a big problem, provided I had a physician who was close who could cover for weekends and that type of thing.

Senator CLARK. What do you see as the importance of this working relationship between the physician and the physician's assistant? How important is that, in your judgment?

Mr. SMUTZER. It has to be very important.

Senator CLARK. Why so?

Mr. SMUTZER. Well, the physician, first of all, has to know the physician's assistant, has to know his limitations and his capabilities. He has to know what the physician's assistant is capable of doing and what maybe he should not be doing. By the same token, a physician's assistant needs a good relationship with his employer. You have to have confidence in the doctor you are working for. And I have a lot of confidence in both Dr. Hamm and Dr. Powell.

Senator CLARK. Well, Dr. Hamm, do you see this as a possible answer to the problem of rural health care? In other words, group practices conceivably with satellites? It may not be exactly the answer here with your relationship to Sioux City, but do you see that as part of the solution to the problem of providing health care for all or most of the small communities of the State?

Dr. HAMM. Yes, I think this is a good possibility; and if physicians are going to continue to be reluctant to come into these areas, I think this is the logical next step. I have, for instance, in working with Don at our office, now, we had even talked of doing this type of thing, perhaps using him as an extension of our services there. But we found that with him in the office, we're all three as busy as we can be right now.

But it's not hard to see an extension of this kind of thing in some of the surrounding communities. There's the mechanics of extending oneself into satellite clinics a little bit. Just the thought of that is a little cumbersome, but I think it can be done, and I think this is a very real possibility.

Senator CLARK. Let me finish with Howard, where we started, and see what he thinks of this. Now, suppose that you have tried 12 years to get a physician. You're not able to get one. What would you think of the idea of having—well, let's just say theoretically with the group practice in Kingsley, where it provides someone like Don—a physician's assistant? Maybe we're personalizing this too much, so it's a little bit difficult for you to say no.

So maybe just theoretically, suppose you had a clinic here with a full-time physician's assistant, well trained in these basic things, emergency care and so forth, under the direct supervision of a doctor, with the realization that the doctor was going to come to that clinic part of the time and with the realization that there is ambulance service to that doctor, to that hospital. Would that be something that would be practical for some community or other communities of this size, do you think, to begin to address the problem of health care?

Mr. LOGAN. Yes; I have a very positive thought about that. I feel that this would be something that would be an alternate. Of course, I'm not familiar with just how much training a physician's assistant has, but I think it's a matter of confidence. I've always made the statement that it takes a professional man about 5 years in a small community to win the confidence of the community; and from then on, why, then he's a member. But up to that point, why, he might move away.

And so, if you had a program—that, maybe I'd say, is too strong, to say we've got to have a whole lot more doctors; but if we did have some halfway situation like this, I think it would be very practical.

We are fortunate here in that we do have a four-lane road into those hospitals. We have the emergency care, and if we could get—I feel that our two areas that we really need help are in the older people—the geriatrics—and in the babies—the pediatrics—so that our people don't have to drive and wait and so on for medical care quite so far and spend so much time doing it.

Senator CLARK. Do you think the people of this community would, over a period, as you say, of 4 or 5 years perhaps come to accept a physician's assistant as a part of the answer for this kind of problem?

Mr. LOGAN. Yes; I definitely do. We do have an osteopathic physician here. He is semiretired, but he still keeps his office open.

Senator CLARK. Good. So you do have some care in that respect, clearly?

Mr. LOGAN. Yes; we do have some care in that respect, and I'm sure the community of Merville would welcome a physician's assistant.

Senator CLARK. Well, that's interesting, because it may be that that's the direction. As I said, we happened to hold some hearings over west of Des Moines, the little community of Grimes, and we have the doctors in there from Boone who had this satellite clinic in Madrid; and again, a community of 2,500, no hospital, no physician at all, and been searching for a long time, absolutely couldn't find any.

He's been there now 5 years, and it's just remarkable when you talk to the people in that community. They have an enormous confidence in the man, and he's just busier than he ought to be, just that busy in that community; and of course, as I say, he works very directly and very carefully with the physicians in Boone. I think he is the president of the Physician's Assistants in Iowa or something like that. His name is Pustka, Rich Pustka. But it's a good example, I think, of how this might work; because I'm still somewhat reluctant to believe, just based on the past and present history, that simply turning out more physicians in the medical school is going to be the answer.

The fact is that we turn out in Iowa, I believe, twice as many physicians every year as we turned out 15 years ago, and yet we have fewer and fewer physicians in the rural communities. We're trying to get some statistics to release here in a day or two. We want to verify them, but we think that the latest statistics again are going to show that a great number of rural communities have fewer physicians now than they had even 2 or 3 years ago. In other words, the trend toward the rural areas is still continuing to decline, compared to the number who are retiring or dying in the most rural communities. So it's just not necessarily the case that if you just keep doubling the number of people who are coming out of these medical schools, that that will come to rural areas. That has not been the trend in Iowa or in the country.

So we have got to find some way, I think, to extend, have a physician's extender like physician's assistants and so forth, in addition to trying to do everything we can to get physicians themselves. Does anyone want to make any other comment at all? If not, thank you, very much. We will go on to the next panel. Thank you. If you can

stay around for another hour, the three of you, there may be some questions and so forth. If you can't, we understand that, too.

Let's have the next panel. Ronald Zoutendam, Dr. Zoutendam, a physician at Sheldon, come right on up. And Jack Myers, a physician's assistant at Sheldon Clinic, and Vennetta Fiedler, from Spencer. Now, I spent a couple of days in Spencer, yesterday and the day before, and came through Sheldon and stopped there for a while. I think, Doctor, we'll start with you, and you just proceed in any way you think appropriate about what's happening up in Sheldon and just any thought you may have about this problem.

STATEMENT OF RONALD L. ZOUTENDAM, M.D., SHELDON, IOWA

Dr. ZOUTENDAM. I'm Dr. Zoutendam, from Sheldon. Perhaps at this point, you ought to have a doctor's wife instead of another physician.

Senator CLARK. Maybe so. We'll have to think about that.

Dr. ZOUTENDAM. I'm one of three solo physicians in Sheldon, which is very close to one of the red shaded areas on the map up here. In fact, we're situated near the corner of O'Brien County and consequently serve, in addition to the little over 4,500 people in Sheldon, a part of the northwest corner of our county as well as part of Osceola County, Lyon County, and Sioux County. Again, this points out that many times, county lines really have little to do with the problem.

We have a hospital, a 35-bed community hospital with an extended care unit. We also have a general surgeon who is in solo practice in Sheldon and who does work in each of four hospitals, one of which is the Sheldon Hospital.

I would like to correct—maybe I have alluded to it—the statement or the assumption Senator Clark had that I'm part of the Sheldon Clinic. And we do not have a "clinic" as such. One of the other family physicians and I do share an office. It seems that the problem, of course, has been talked about to a considerable extent. However, we are a community, as I said, of 4,500, and I am the youngest doctor in the community of Sheldon and the second youngest, as a matter of fact, in our county. And if we look at the total area of our four counties, since I came to Sheldon 17 years ago, we have recruited or obtained very few additional young physicians.

The physician population has declined, as, of course, has the general population to a small extent. The problem of not enough family physicians in general has been alluded to, as well as the possible solution of turning out more. And, of course, the problem of the maldistribution, which is really the problem and which will not necessarily be solved, I'm sure, by the increase in physicians. The maldistribution is really the problem.

Then, of course, we can talk about the solution. The idea of having more physicians turned out from the medical schools has been mentioned. Certainly I do believe, and I think most people would agree, that the increased emphasis on family practice and the increased number of residencies in Iowa, specifically in family practice, should help the situation to some extent. If the Federal Government wants to exert its influence, I would suppose that continuing to support these family practice residencies—which by themselves certainly

cannot pay their own way—would be an important area that should be continued to be pursued.

As far as the distribution of physicians, of course, is concerned, many of the things which the Federal Government and also the State government have done in the past have really not helped this for various reasons. The carrot which you know has been dangled by small communities, by States, and by the Federal Government many times has been bitten off, but you haven't trapped anybody, because financial inducements alone, medical buildings alone, do not necessarily make a physician want to come to this or that particular community.

The idea of paramedical personnel which has been discussed now quite a bit, is a very important, I believe, and a viable approach solving at least some of our problems. Getting back to the idea—to the fact, however, that many of the approaches so far have not helped, in other words, the health planning councils—I don't know how active you are. I presume you have something to do with that?

Mrs. FIEDLER. No, our administrator did.

Dr. ZOUTENDAM. I see. By and large, they've tended to concentrate on the—have tended to help centralize rather than decentralize medical care. At least, I feel that way. I think Government assumption of the cost of medical care has in many senses tended to do the same thing. It has been mentioned, for example, that physician's assistants and paramedical people cannot be paid for by medicare and medicaid. In addition to this fact—and this, of course, is a controversial thing even among physicians—the fee and reimbursement setup tends to continue to pay higher fees where higher fees have been charged, and continues to pay lower fees where lower fees have been charged; and consequently, physicians in rural areas who have traditionally charged the lower fees are trapped by the same thing, in that it's very difficult to raise one's fees, at least in terms of medicare and medicaid.

I believe this has some part to play in the fact that when physicians look at the economics, they (young physicians, new physicians, people looking for a place to practice) at least take this into consideration. I think the money that has been put out in terms of helping build and/or improve and enlarge and remodel hospitals has tended to centralize rather than decentralize medical care. One example—and we hold no grudges about this—but at the time that our hospital was attempting to get some Federal money for the enlargement of our hospital (not to add any beds, but to enlarge our support facilities), at that time, several other hospitals got money, including the University of Iowa, who got 90 percent of their asking, whereas we did not get 50 percent of our construction cost.

Senator CLARK. This is the Hill-Burton funds, were they, do you remember?

Dr. ZOUTENDAM. Yes. I don't think it was called Hill-Burton, but that's what it was. This is 5 years ago, I presume. In general, I believe that the local situation, the local and community effort is still most important. We obviously don't have any real success story, and of course, I suppose the reason we're having this hearing is that many, many, many communities do not have a success story. So I believe that the Federal Government should, of course, support medical education specifically, and with emphasis on the family

physician. And in addition to this, I think if Federal moneys are to be spent, they should also emphasize the training and continuation of programs to train paramedical personnel.

A year and a half ago, or almost a year and a half ago, I employed a physician's assistant who is with us this afternoon. I feel he has been very well trained and has provided a great deal to my practice in Sheldon. Of course, this whole concept is not without some problem, not the least of which at the present time is physician acceptance of this particular concept.

Senator CLARK. I'll bet so.

Dr. ZOUTENDAM. The physicians in our own community, other than myself, are not necessarily sold on this. This has not caused big problems, but it has caused some problems. The problem, of course, is potential abuse of this sort of system, I think, exists. I'm not sure it is any more of a problem than abuse of physicians' time and knowledge in general, but certainly it does exist. And I also believe that the more the concept is extended into satellite clinics, the more this potential of abuse, of course, could exist.

Many people criticize the concept on the basis of feeling that it offers second-rate or poorer medical care. I believe that this is not true, or at least that it certainly need not be true. My physician's assistant—as he can perhaps tell you better than I can—helps a great deal with patient education. He helps a great deal, as far as I'm concerned, in terms of having an additional person around to discuss problems with or to perhaps even argue about certain things with me in terms of care of patients. In addition to this, of course, he does free me for doing things which I would and could not have time to do otherwise, in addition to his being available when I may not be right next to the phone or at home or in the office or in the hospital, so that he can see people first and contact me or handle a little problem in the best way he sees it. At this particular point, I think that's all I have to say.

Senator CLARK. Good. That's a good start, and I want to come back and ask you some more about that, because you raised a lot of good questions, I think, that are very relevant to what we're talking about here. Well, let's go to the physician's assistant, Jack Myers, who works with Dr. Zoutendam in Sheldon. And I wish you might tell us a little about your own background and training, if you could, if you're prepared to do that. Where did you come from? How did you happen to get into this business? What attracted you? Where were you trained? What kind of training did you have?

**STATEMENT OF JACK EDWARD MYERS, PHYSICIAN'S ASSISTANT,
SHELDON, IOWA**

Mr. MYERS. I went to the University of Iowa for my B.S. with mainly a science major. Following that, I applied to the P.A. program at the University of Iowa.

Senator CLARK. P.A. is a physician's assistant?

Mr. MYERS. Yes, physician's assistant program. At that time, they didn't feel that I had enough experience. My educational abilities they thought were adequate, but I hadn't been exposed to enough medical care. So I went and worked in an emergency room for 1 year.

I reapplied at the University of Iowa, and was accepted; and I graduated 24 months later.

Senator CLARK. When did you graduate'?

Mr. MYERS. Spring of 1975.

Senator CLARK. So you have been out a little over a year—year and a half—something like that?

Mr. MYERS. Right.

Senator CLARK. What kind of training did you get? I mean, what did they train you to be able to do?

Mr. MYERS. OK. The first 12 months of our training is primarily what freshmen and sophomore medical students get. We have the same anatomy courses. Many of our courses are along with these students. However, the emphasis is placed on primary care. The care is more of what we see in a community or a family practitioner's office. Our second 12 months has an emphasis of more of the specialties, where we spend so many months in each of such as pediatrics, obstetrics, internal medicine—that type of thing. And, again, the settings have more of the primary care emphasis than university students get in the College of Medicine. For example, I spent many months at Broadlawn in Des Moines, which is a county hospital with lots of primary care and secondary care.

Senator CLARK. Well, I just wanted to start you on that track. You go ahead and say anything else that you may wish to.

Mr. MYERS. Well, as I was saying, my training and experience qualify me to take histories, to do physicals. I know how to interpret laboratory data, to make diagnoses, and initiate treatment for most of the common illnesses and ailments. I'm also trained to recognize the more serious illnesses that are beyond my scope. My training included that of suturing, applying casts, biopsying lesions and doing diagnostic procedures. All of this, however, though, is under the supervision of some type of your physician, who has to be licensed to qualify.

I've worked with Dr. Zoutendam for about 1½ years in Sheldon. During that time, our patient acceptance has been very good, and I agree with him. I think our patients are getting better medical care now. Not that I'm practicing any better medicine, but now—one of us has more time to spend with the patients, discussing their illness, their treatment, and I think more important, their patient education towards preventive medicine.

Senator CLARK. I think that's exactly the point. The three or four sentences you said there is really where it is. I think the average person says, "Well, gee, how could you get better health care from a physician's assistant than you get from the physician?" Well, that isn't quite the point. The point is, it seems to me, that physicians are badly overworked. They're going to need their time for those things that must require their attention; and if they do that, it seems to me they're going to have less and less time to deal with things like preventive medicine, with things like being able to sit down with somebody in a less—what's the right word?—frantic way and be able to talk with that somebody at length.

It seems to me that has to be providing people with a good deal more quality health care in the long run than just having a desperately overworked doctor at all times. Go ahead.

Mr. MYERS. That was my second part, and also I can lighten his load by reducing his daily patient contact as well as relieving him of some of his night calls and weekend calls. With this type of physician/physician's assistant or P.A. relationship, a family practitioner can still stay in a rural practice without having the heavy workload 24 hours a day, 7 days a week. I feel that's one of the main reasons physicians leave the solo rural practice and join a more urban community with a group practice.

As you mentioned before, physician's assistants are handicapped as well as, I guess, are the physicians, by the nonreimbursement of medicare.

If reimbursement under this plan were made available, these patients would have better care. It makes the possibility of house calls, nursing home visits to these people in nearby communities more likely, due to the fact that the family practitioner can't do this with his heavier workload. So I guess my two points are: one, the use of P.A.'s to encourage and maintain physicians in the rural areas; and the financial reimbursement to physicians for physician's assistant services.

Senator CLARK. Good, excellent. Vennetta Fiedler, you may proceed in any way you think appropriate. I just spent a couple of days in Spencer, a very attractive community—a community of about 10,500. Can you tell us anything about your experiences with health care?

STATEMENT OF VENNETTA N. FIEDLER, SPENCER, IOWA

Mrs. FIEDLER. First, I would like to say I did hear your tape. I was unable to attend any of the appearances you made and I was interested in your tape extolling the, I suppose, beauty of Spencer and the fact that we seem to be headed toward an increase of population through industry.

This will be somewhat different than what has been presented before, and maybe just a bit redundant for the doctors in the audience. When I say this, I have been formerly a social worker. This is not welfare social work. I have been most recently a medical social consultant or coordinator at the Spencer Municipal Hospital. Prior to that, I was—David asked me to do this, or I wouldn't have talked about myself. He wanted me to give a little bit of background of why I am here, I guess.

Senator CLARK. That's a good idea.

Mrs. FIEDLER. Prior to that, I was instrumental under the Commission of Aging in setting up the Iowa Lakes Community Home-maker Helping Services in a five-county area. And at that time, O'Brien County, I think, was just coming into that. Before that, I was with the American Red Cross. I have been—I am a nurse, graduated from the Chicago School of Nursing way back when. I attended several colleges, working toward a social degree, and I became a part of the Spencer Municipal Hospital staff through the Commission on Aging.

It was a pilot project. They put me there so that we would not have overlapping of services with the welfare services and the public health nursing; and I'm just recently able to have convinced my director or the administrator, Mr. Earheart, that he would accept my resignation. I've been trying to resign since last January.

Senator CLARK. Now, this hearing is to try and attract people, not try to convince them to leave.

Mrs. FIEDLER. I'm hurrying along to say to Dr. Zoutendam that I've seen his referrals to our lady urologist over my desk many times. This will touch on a sore point, I think perhaps a controversial thing. I also have set up—I was the coordinator for our hospital P.S.R.O. review we're probably going to enter into under medicare.

It's good to be here in Menville. I've never been here myself. My only claim to fame in this area is when I speak of Kingsley, those of you who are acquainted around Kingsley probably know the Crabb family, and my daughter is married to Dr. Gerald Crabb's young son Tom. So to those of you, I know there are some Crabbs yet living on the farms around Kingsley. Health needs, if I may just read this for the written record?

Senator CLARK. Fine.

Mrs. FIEDLER. Dave asked me only 1 minute per page, please.

Senator CLARK. All right. I'll have Dave time you.

Mrs. FIEDLER. Health needs and practices have become one of the most emphasized and highly touted elements in the 20th century, and why not? Good physical and mental well-being is vital, and our Nation and indeed the whole world cannot afford to have progress impeded by pressures put on us because we are unable to obtain and solve our health plans. As you all know, heart conditions and arteriosclerosis are among the dreaded diagnoses of our society. Of course, we all like to enjoy a peptic ulcer. This is supposed to be the No. 1 occupational hazard, I believe.

The illnesses today that we combat are not limited to the aging or to the obese, but to the young and the infants. They are also victims of various illnesses, and some succumb to some which remain undiagnosed. And here, I want to ad-lib. Diseases that we have not recognized before because they are rather new to our areas, they really occupy our physicians' time. Viruses that are unknown come into being, and we go through a little epidemic of some type of virus; and the physicians must try to isolate it so it can be treated.

Just a homely reference. My daughter and I were out in Arizona at the birth of my first grandchild, and during this time, we decided to take a hike out into the mountains or the foothills around Tucson, and there was a dust storm came into the valley that day, and we walked back through a dust storm. We returned back to Iowa, and about 6 weeks later my daughter became very ill, and the doctors who were attending her—and I'm sure that there were several who had conferences about her illness—were unable to diagnose it, finding out later that she had been infected with coccidioidomycosis, which is really native to Arizona. It's a valley fever, where it's supposed to be in the dusty areas rather than in Iowa. But this is just one isolated case.

Our society is so mobile that—I think I'm kind of taking the side of physicians needing to be near hospitals in this instance—that many of the illnesses can remain undiagnosed if they do not have the more sophisticated types of diagnostic—well, what do I want to say?—diagnostic equipment. The X-rays and the various types of CBC's that are done are very sophisticated now, and I do understand why physicians would not like to be too isolated from hospitals where this can be done.

Just recently, we were all frightened a bit about the flu vaccine. We thought that perhaps it might be adulterated, but we have found now through tests that this swine flu—I guess they call it the bicentennial flu, where people are raising swine. They don't like to have it called swine flu. So I believe it's the bicentennial flu in our area. We find now that this vaccine is pure, but this will inhibit people, older people, from going to have this vaccine. Some of them will not do this and consequently will probably contact a flu virus. And here again, doctors who are overworked will have this type of a problem to deal with.

Programs designed to alleviate health needs also cause persons to become overanxious and cautious of their own aches and pains, and then many in the lower income groups who are being subsidized by ADC title 19 in various State and Federal programs prevail themselves of the physician's care, where those in the lower and middle income brackets do not go because they feel like they can stand their illness or at least try to cure it themselves, rather than go to receive costly treatment. The needs are pronounced. You know the needs. The solutions are more elusive. Why are doctors not being attracted to the rural cities and towns? Obviously, one reason could be the very busy rural atmosphere. They also lack the social and—I should not say "luxury," but it is a luxury to be able to go and take in a cultural show or be able to avail yourself of the companionship of other physicians where you're remotely removed from them.

Second, I think something that we haven't touched on, perhaps, is the high cost of equipment to set up a good physician's office, and the staffing required and the insurance girls you must have. Because of medicare and Blue Cross and Blue Shield and all the private insurance, you must have a very well trained and skillful insurance girl. They must have a receptionist. They must have nurses, probably one or two, and this alone is out-of-pocket money unless they can get funding.

Senator CLARK. Malpractice, too, is another one.

Mrs. FIEDLER. Right. I was thinking of that in terms of the P.A.'s. I don't know if this has become easier or not. There was a physician at Lake Park who a few years ago had a P.A. with him, and because of the malpractice insurance, the rate was so high he could not continue on in this. All right. Briefly, our State's most fortunate to have a vital segment of a health team available to us.

I want to hold out and give what I think is one of the vital links to our physicians, and this is public health nursing. The public health nurse is, I suppose, almost invaluable in our community, and in Spencer we have three registered nurses staffing the public health office, and of course, they travel only in Clay County. But Woodbury County, I understand, has a very, very active public health nursing service. I don't know if any of you are out of Sioux City, but I understand that they're very sophisticated. Under them, you might be able to obtain the Homemaking Health Aid Services to maintain the elderly in their homes.

The only thing in our community, we do not have Homemaker Health Aids to stay 24 hours. Eight hours seems to be the extent of the care that they deliver. There are also "Meals on Wheels," "mothers and babies services," "Planned Parenthood," "procurement of ortho-

pedic appliances and supplies," and of course, the nurse will visit the home under the doctor's supervision. And they would even, where there is oxygen required in the home, the nurse herself will help set this up and teach someone inside the household to give the oxygen.

They are also the vital link with the physician, because they do report back to him on a daily basis, if necessary. I would like to mention one of the things, one of the ways I feel that we might alleviate some of the needs, the health needs, and that is "Well Persons Clinics." Marshalltown has a Well Elderly Clinic, which is staffed, I believe, once a month. I think it's the last Friday of the month, and they have the staff comprised of public health nursing, visiting nurses, someone from the medical staff, laboratory technicians, and there might be others. There are those who take the social histories and so forth. This is done once a month, and then if there are any problems presented within this clinic, the patient is referred to his own physician and the physician is given all of the histories, et cetera that were taken at that time.

I think that the funding for that in Marshalltown came from several organizations. Private organizations and civic organizations love to be involved in this sort of thing, but I do think revenue sharing could play an important part in this type of a clinic. This is really all I have to say. I have hurried through it, because I know our time is very limited.

Senator CLARK. Good. Let me start with questions with you, if I may, and then I want to come back to the unique situation in Sheldon and so forth, as an example, of funds. You have talked about this just a little right in the closing part of your statement. But besides medical care in general, several other services are necessary, as you have said, for comprehensive health care. Do you think that these services, such as home health care, public nursing, nutrition programs, like congregate meals or meals on wheels and so forth, do you see these as needed? Do we need to expose those in rural areas, or are we rather adequately serving the rural areas now, in those areas?

Mrs. FIEDLER. Thank you, Senator. I feel that in our community, and this is Clay County and Spencer, we serve only Spencer itself. The small towns in the outlying counties are not being served. Yes; I think it should be expanded.

Senator CLARK. And I did notice when I was there that there are apparently, or at least according to the people I talked to, no congregate meals program in Spencer.

Mrs. FIEDLER. They had tried it and it failed. I feel that the meals on wheels is far superior, because in our own area, a physician must recommend and prescribe the diet that will be given to this particular patient; and we do not prepare nor serve them wholesale. They are sent out from the hospital. But it is a volunteer endeavor. But the physician himself must so state that the patient needs to have this type of service.

Senator CLARK. Now, do you have any idea what percentage of the people in northwest Iowa or that general area that you live in are over 60, over 65?

Mrs. FIEDLER. I knew that you were going to ask that. I knew that 3 years ago, but I don't know. I'm sorry.

Senator CLARK. You don't remember it?

Mrs. FIEDLER. I'm sorry. No.

Senator CLARK. Well, I'm sure it's something like, in the smaller communities, 15 percent.

Mrs. FIEDLER. Probably.

Senator CLARK. And we had some counties—I think Davis County, which is down in south central Iowa, is now up to 23 percent. But I would guess that Clay County and O'Brien County, that general area, is probably around 15 percent, give or take 4 or 5 percent.

Mrs. FIEDLER. I believe Dickinson County, if I remember rightly, has the largest percentage of elderly in our northwest Iowa.

Senator CLARK. Do you think that presents any special problems for health care in rural areas, the fact that you have——

Mrs. FIEDLER. Aging?

Senator CLARK [continuing]. A higher percentage of elderly?

Mrs. FIEDLER. Well, it really could take a good deal of a doctor's time, as far as that, yes; yes, I do.

Senator CLARK. And lastly, what about health care in Spencer? In talking with people there yesterday and the day before, I gathered that, at least with people that I talked to—that may not be representative and may not be accurate—they felt that Spencer, which is a community of 10,500 and very isolated in the sense of being 100 miles from any larger communities on any side, whether it's Sioux Falls, Sioux City, Waterloo, or Mason City or Fort Dodge, that that community had very adequate health care services. Do you agree with that or do you not?

Mrs. FIEDLER. I think they're super, the health care that we have. But it's a limited amount, since the doctors seem to be overworked, as they are in all areas. And our doctors, I think that the youngest is Dr. Kelly, and I would assume he is—he'll hate me if I say he's 40, but I'm sure he must be nearing 40. And our doctors are getting, some of them, near retirement. Isn't that true, Dr. Zoutendam? Dr. Zoutendam is an associate member of our staff. Is that right?

Dr. ZOUTENDAM. Yes.

Mrs. FIEDLER. That's correct; so he can tell you more about them than I.

Senator CLARK. Do you remember how many physicians you have who are practicing in Spencer?

Mrs. FIEDLER. Ten active.

Senator CLARK. So you have 10 in a community of 10,500. But of course, you serve a much larger area along with other doctors?

Mrs. FIEDLER. But we claim Dr. Zoutendam, also.

Senator CLARK. He's one you claim?

Mrs. FIEDLER. Yes; the Sioux Rapids doctor and various small-town doctors are on this.

Senator CLARK. But you have come very close in that community, you see, to providing quite a good—you have got a new hospital?

Mrs. FIEDLER. Right.

Senator CLARK. And the question, I guess, is—why do you attract so many physicians?

Mrs. FIEDLER. Well, I suppose it seems to be a progressive town, but yet I have been in Sheldon and I have felt that Sheldon is progressive. I don't think it's the progressiveness alone. Perhaps the fact that we have some specialists on the staff might make this more,

you know, attractive to other physicians coming. If you were to ask our staff, our medical staff, I'm sure they would say that we are not adequately staffed. We do need more.

Senator CLARK. Yes.

Mrs. FIEDLER. Right.

Senator CLARK. I'm sure that's true in terms of specialization and so forth. I see here David says—he knows all these statistics—that 17 percent of the people in Clay County are over 60 years old.

Mrs. FIEDLER. Thank you, David.

Senator CLARK. Well, now I want to ask Dr. Zoutendam. What prompted you, to return to this rural health care problem? What prompted you to hire a physician's assistant? Why did you think that was a good idea?

Dr. ZOUTENDAM. Well, going back to the whole problem that there are three family physicians in Sheldon. We are all solo. This originally, of course, has been a matter of choice, and there are still a few of us who feel that being in solo practice really has some advantages.

Senator CLARK. Would you talk a little about that?

Dr. ZOUTENDAM. I would defend the advantages, but I also realize that in the present day that the disadvantages are starting to catch up.

Senator CLARK. I see.

Dr. ZOUTENDAM. Well, the advantages are that you are your own boss. If associated with other solo physicians, which I am in terms of getting along well, we see each other's patients when we're not available, and yet we don't have any economic arguments. We each charge our own patients, and if we see—including the physician, for instance, with whom I office—if I see his patients evenings, weekends, holidays, I charge them as if they were mine and try to send the patient back to him when he was available. We've had a good working relationship. We like it that way. We have a certain amount of independence that we just do not have—would not have if we were in a corporation or a group.

Senator CLARK. But do you sometimes consult on occasion?

Dr. ZOUTENDAM. Oh, certainly, certainly. I came into Sheldon as a solo physician when there were more physicians in Sheldon then. In fact, all the other physicians were in a group and for various reasons the group dissolved. But, of course, the disadvantage, as far as I am concerned, and as far as we are concerned right now, is attracting additional young physicians is very difficult under these circumstances. Now, I know there are exceptions. Occasionally, one will find doctors going alone into a small community or a community our size, and we would like very much to have two additional family physicians come into Sheldon, either form a group of their own, a partnership, or to come in solo.

In fact, I haven't signed it yet, but I'm soon going to sign my name on the line for a note to expand our building for a physician to come in with me, or come in alone, or however he wants to come in, or two of them. But anyway, we haven't been successful up to this point in attracting any additional physicians.

And to divert just a little bit in terms of Spencer's situation, I think the Spencer situation really is not all that different, other than they are larger. But they are in the center of the county and

the only large town in the county; and if you take all that into consideration, they don't have enough physicians, either.

Senator CLARK. In other words, the doctor/patient ratio is about the same, roughly speaking?

Dr. ZOUTENDAM. I would say yes, but I don't know.

But at any rate, I felt that perhaps to relieve my load that it would be feasible to hire a physician's assistant, provided I could find one with whom I felt I could get along with well professionally as well as other ways, and when I found Mr. Myers, it seemed like this would work out, and indeed it has, as far as I'm concerned.

Senator CLARK. It's worked well in your case?

Dr. ZOUTENDAM. Yes.

Senator CLARK. And it's given more time?

Dr. ZOUTENDAM. Yes. It's given me more time in many respects. However, it also has tied me down in other respects. As I understand the law to be right now, and the way the licensure of both the physician's assistant and the physician who is licensed to employ one, the physician's assistant really is not to work unless the physician is available. Consequently, the way things are at the present time, if I take a vacation, Jack takes a vacation, and if I leave town, he leaves town.

Now, I can get five miles out of town, because with him working, once in a while, because I have a beeper. So there are both sides to it.

Senator CLARK. Well, does it give you, not more time off, but does it give you more time with your patients? Or let me put it another way. Do your patients get better health care, better quality health care because of your addition of Jack?

Dr. ZOUTENDAM. Well, I think we always get into a little dangerous territory when we evaluate ourselves, the health care that we're giving. But I would say yes, I do have more time and spend more time with some patients. I have more time and spend more time talking about these patients, if to no one else but to Jack Myers, and it has I feel, been beneficial to me and to my patients in that I have explored several things which I wasn't motivated to explore before, or didn't have time.

Senator CLARK. Do you think that the Federal Government, medicare and medicaid, ought to reimburse a physician's assistant and nurse practitioners for their work with elderly people?

Dr. ZOUTENDAM. Well, I think as long as the Federal Government is in this business—

Senator CLARK. Well, that's what I mean. You may prefer not to have medicaid or medicare at all, but assuming you have got it.

Dr. ZOUTENDAM. I feel that the employer of the physician's assistant should be reimbursed if comparable care is given by the physician's assistant or a nurse practitioner.

Senator CLARK. You would endorse that idea?

Dr. ZOUTENDAM. Yes.

Senator CLARK. You said you came to Sheldon, I think, Doctor, what, in 19— What did you say?

Dr. ZOUTENDAM. 1959.

Senator CLARK. 1959. And how many physicians were there in Sheldon, do you recall, at that time?

Dr. ZOUTENDAM. For a short time, there were five.

Senator CLARK. And now there are—

Dr. ZOUTENDAM. Now there are four, one of whom is a general surgeon who does no primary care whatsoever.

Senator CLARK. So there are three, three compared to five; is that the right comparison?

Dr. ZOUTENDAM. Right.

Senator CLARK. Since 1959. And what, roughly speaking, are the ages of the other two?

Dr. ZOUTENDAM. Their ages are 52 and 61.

Senator CLARK. So that the trend in your area, is this pretty representative of the trend throughout that area, in your judgment, is continuing to go downward? Or let's put it this way, the doctor/patient ratio is continuing to grow?

Dr. ZOUTENDAM. Well, it seems that way; yes.

Senator CLARK. What in your judgment is the answer to this? We talked to the earlier panel about establishing practices as you have in Sheldon, perhaps, and then satellite clinics. You mentioned in passing that the further away, in a sense, that the physician's assistants get, the more difficult it is to have a good, close relationship there, one that provides quality health care. Is that a part of the answer, or is there some other answer?

Dr. ZOUTENDAM. Well, I don't certainly know the answer. I think that satellite clinics may be a part of the answer. As a physician right now, presently under the setup, the present circumstances, I would be reluctant to put a physician's assistant under my care in a satellite community.

Senator CLARK. Expand on that a little bit.

Dr. ZOUTENDAM. I'm quite happy at the present time with one physician's assistant working in the same office, in the same hospital, perhaps making some house calls, nursing home visits, and seeing a few people for me in the emergency room while I may be at home or in town. I'm quite happy with this; but I feel I would be extending myself to some extent more than I'd want to extend myself if I had one in Sanborn or one of the other small communities around Sheldon.

This is another point which I believe was mentioned in the earlier panel. A physician's assistant and a physician, it takes a long time for the two of them to be able to really work together in terms of each of them knowing what the other is thinking or would want to do under certain circumstances. And so it could very easily be that in 5 years I would be perfectly happy to have Jack Myers in a situation like that. And the fact that I am not now is really no reflection on what I feel are his capabilities or his training.

Senator CLARK. Right. It just takes time to develop that kind of training—

Dr. ZOUTENDAM. Right.

Senator CLARK [continuing]. And his experience as well. But do you think that concept has some future; and if not, where does the future lie for health care for the Movilles of this State and this country?

Dr. ZOUTENDAM. I don't know how to answer that. I have all sorts of problems figuring out how to handle things in a community of 4,500.

Senator CLARK. It's hard to know what direction we ought to take, whether to encourage these satellite clinics with physician's assistants, nurse practitioners, or not.

Dr. ZOUTENDAM. I think the concept is good, if extended the right way. In other words, I believe that if a clinic or group—for instance, in Boone, the man in Madrid is responsible to a whole group of physicians. No one physician is necessarily tied down with knowing all the time what's going on in Madrid.

Senator CLARK. There are two physicians in Boone that he works with.

Dr. ZOUTENDAM. Two?

Senator CLARK. Right.

Dr. ZOUTENDAM. So I'm in favor of the concept.

Senator CLARK. That's what I'm wondering.

Dr. ZOUTENDAM. I do think, however, that the law as it is in Iowa and as these people are licensed, there are still some real restrictions. For example, a physician's assistant is not legally authorized to prescribe medicine, which is somewhat inconsistent, because he has been trained and he is legally empowered to treat.

Senator CLARK. I was interested earlier, if you might expand just a little on why you feel health planning in Iowa as it's developed, from your opinion, does lead to centralization of resources. Could you expand a little on that?

Dr. ZOUTENDAM. Health planning, while it has certainly many, many good points, always has the problem of being, first of all, somewhat of a bureaucracy. It tries to, I believe, it honestly tries to have representation from all areas of its given constituency or number of communities. But, for example—and this may be our fault—the way I understand it right now, our county is represented on the present health planning board by one person, namely, a lay person whose name I do not recall, from Sutherland, which is about as far from Sheldon as you can get and still be in the same county.

Now, that in itself doesn't worry me, other than the medical community in O'Brien County nor the hospital community in O'Brien County is really not represented at all.

Senator CLARK. I see. And you feel that might tend to lead towards a greater centralization?

Dr. ZOUTENDAM. Well, just our lakes area planning area has now been dissolved to take in a larger area, with Sioux City as a center. I think—just look at what's happened. Figure it out. We're further toward the tail than we were before.

Senator CLARK. I was interested in your other statement that I've heard once before, and I wanted you to expand on it if you could, namely, that medicare and medicaid sort of work against attracting physicians to rural areas because their payments are based on historically paid payments, I guess is the right way to say it. In other words, on payments of the past, and that as a result, if the more rural area has had a history of smaller doctor and hospital bills, that they will pay a smaller amount than they will for equal treatment for an equal illness in a city. That's an interesting point that I thought we might try to look into more. Can we talk about that a little more?

Dr. ZOUTENDAM. Whenever one has third-party payment, whether it be insurance or any aspect of the government, these kinds of problems will creep in or exist.

Senator CLARK. It's insurance as well as medicare and medicaid?

Dr. ZOUTENDAM. Yes. There is no other way but what these problems are going to exist when the problem was between the physician and his patient. I provide this service for a fee of such and such, and if you can't pay it, we'll try to find some way other, or you're going to get it at a reduced fee or for nothing.

When that was the situation, then at least physicians were free to charge what they felt was right, and nobody complained about it. Now, also inherent in the problem, of course, is the concept of C.P.R.—no, I've got the wrong—U.C.R., usual, reasonable, and customary. In other words, physicians have hung to that, and I believe they should. If we're going to preserve any part of free enterprise in our health care system, physicians should be free to charge what they want to, and if patients in the community don't like it, he's soon going to find out.

However, third-party payments have made this much more cumbersome, so fee schedules have had to be set up. So if you live in an area where office calls are \$10, that is what medicare pays you, except when office calls go up, which like anything else is inevitable it takes approximately 1 year or longer for that to catch up. On the other hand, in California, office calls certainly are more than that, and medicare certainly pays more than that. But to bring it back to the local area, doctors in urban and suburban areas do charge more and are reimbursed more by medicare. I'm not saying that that's entirely wrong.

Senator CLARK. No; I understand. But as a new physician goes out and looks at the situation, he knows or she knows.

Dr. ZOUTENDAM. He knows that his fees are sort of locked in. The usual part, of course, and the reasonable and customary—those are concepts we could talk about a long time—are somewhat locked in for that given community, especially in terms of third-party payments.

Senator CLARK. Let me ask you lastly a somewhat more difficult and, I guess, theoretical question. As you say, you're worrying about Sheldon and that area, and not about the whole world. But do you think, just based on your own practice in a rural community and looking at others and knowing a lot about this profession and so forth, do you think that Iowa communities and communities around the country of, let us say, 1,000, are ever going to have a physician in each of them? Is that what's going to happen over a period of years or decades? Or should we rule that out?

Dr. ZOUTENDAM. Would I say that physicians—or communities of 1,000 will not have physicians? I think that's a fair statement.

Senator CLARK. They're probably just not ever going to attract physicians, so that we do have to go to some other kind of a satellite concept?

Dr. ZOUTENDAM. However, I think we've got to take some other things into consideration. And this is not in any way belittling the efforts or wishes of small communities to want physicians, but there are some people living in Merville that are, in terms of minutes,

probably as close to a hospital as there are some people living within or very close to the city limits of Sioux City, Iowa.

I'm not sure that the concentration of physicians in urban communities has necessarily made medical care more accessible. I hear some horrible stories about how long people have to wait and how hard that they do have to work to find a physician or medical care in nonrural communities.

Senator CLARK. Yes. As a matter of fact—and this isn't the subject of this hearing or the jurisdiction of this committee—it's almost exactly the same problem in the ghettos or in the central cities where you have almost the same kind of problem exactly.

Well, let me talk to Jack Myers, who is very central to this whole question of what we can do to extend, if we can't get enough physicians. It seems to be pretty much agreed upon, it doesn't look like we're going to do that. We have got to find these health care extenders, people like yourselves, physician's assistants, nurse practitioners who can assist physicians to extend their ability to serve more people and to serve them better. I'm curious. Now, where were you raised?

Mr. MYERS. Adel. It's in central Iowa.

Senator CLARK. Adel. So you are from a town about the size of Sheldon? So you know something about—

Mr. MYERS. Only half that.

Senator CLARK. What?

Mr. MYERS. About half that.

Senator CLARK. Adel is only about half the size?

Mr. MYERS. 2,000.

Senator CLARK. Well, then you're moving to a big city when you go to Sheldon. What attracted you to Sheldon? Why did you decide to do that? Why didn't you want to go to a larger city or whatever? Why did you happen to go there? And don't just tell me that you fell in love with a young woman there, something like that. Maybe that's the reason. But what attracted you?

Mr. MYERS. I'm interested in primary and secondary type medicine. The patients that you see in a smaller community are patients that tend to appreciate their medical care and time that you spend with them. So you get a little return, you know; maybe not the economical, but you get a lot more in return with satisfaction in treating these patients.

Senator CLARK. I see. A good deal of satisfaction. You know the people. You know when they come back, you know all about who they are and what they are; is that it?

Mr. MYERS. Right.

Senator CLARK. Well, now, how does a physician's assistant, just for the record here, differ from a nurse practitioner? I keep using these terms interchangeably in terms of qualifications of training and responsibility. Do you have the same training exactly?

Mr. MYERS. I can't tell you for sure, but I know just in physician's assistants there are so many different kinds that physician's assistants are as confused as everyone else. It all depends on how you're licensed and your training. There are 4-year schools. Some people are out of high school and have 1 year's worth of experience.

Senator CLARK. But you have to pass a test of some kind, a national test?

Mr. MYERS. Right. There are national ones.

Senator CLARK. I wonder if the nurse practitioner does have to do this?

Mr. MYERS. They are qualified to take the exam if they want to.

Senator CLARK. I see. If they want to, but it's not required?

Mr. MYERS. No.

Senator CLARK. What sort of things do you do on a day-to-day basis? I'd like to just get more practical. Like, what is today, Sunday? What did you do Friday, just to give some examples?

Mr. MYERS. OK. Typically, we start together at the hospital. We review charts. Friday happens to be a surgery morning. If Dr. Zoutendam is in surgery, I would be making rounds, checking on patients. If there's any problems, I make sure that he knows about it when he comes out of surgery. If there have been any admissions or anything like that, I can be doing the history and physical and working the patients up. After that, we generally go to the office, where we work typically, well, whatever—9:30 to noon, then till 5 or whenever we finish.

And then, depending on whether it's my night on call, I go to the hospital, again, review the situation there with our patients, and that evening is whatever happens to come in.

Senator CLARK. All right. Well, that's really, I think, all the questions that I had and thoughts that I have. Would any of you care to add anything else at all? If not, why don't you just stay seated and let's open it up here in case anyone else would like to make a statement or ask a question. Are there any here who would like to express themselves?

Well, before we do that, then, we're going to break, because she's been working pretty hard and pretty fast here. We're going to take about a 3- or 4-minute break; and I guess there's some coffee, so literally 3 or 4 minutes. Then we're going to come back and take another 10 or 15 minutes for comments or questions and so forth. So we'll stand in recess for 4 or 5 minutes.

[A short recess was taken.]

Senator CLARK. Well, I wanted to take another 10 minutes or so here and give anybody an opportunity to make any statements they would like. I'd like to have you identify your name and address, or at least the town, so that we have this on the record. And let me again repeat that we do have these sheets for anyone who may not wish to make a statement here, but would like to write something out. They're self-addressed envelopes, and they're on the table here, along with a lot of other material about rural health care. Just feel free to write those out longhand or anything and mail them to me, and we'll put them in the record here as if given. We can only keep the record open for about another week or 10 days, so we'd like to have you mail them to us in that length of time.

But there is also some time for either questions that people might like to raise with any of us people that have talked, or equally appropriate, anything you'd like to say about rural health care at all. So here we go.

STATEMENT OF JOHN L. GARRED, M.D., WHITING, IOWA

Dr. GARRED. Well, I'm Doctor Garred, and I'm from Whiting, and nobody can get more country than I am, as you know, Senator.

Senator CLARK. That's right. I've stayed over in Whiting.

Dr. GARRED. I live out in the country, and if you've got physician per population, there's about 600 people in town, so this is a smaller town than Menville is. Fortunately, I might be what you call a satellite. I live out close to Onawa, and Onawa is the base, for we have a hospital and it's a central area. I think that I'm in that red area that you see on the map there. I think maybe that that's all solved there, because the Indians are going to take that, and we can use their medicine men. [Laughter.]

Senator CLARK. That's an idea. We haven't considered that.

Dr. GARRED. What really has made us even more short than your map shows is two or three things. We got a bridge that went across into Nebraska, and if you think we're short in our area, wait till you go across the river. So that bridge is quite a funnel, and we have a lot of work come in.

Some points to bring out. The Federal Government has a beautiful hospital at Macy. We have a lot of prejudices over there. The Federal Government doesn't have enough gumption to figure out what Indians like or don't like and their own feelings, so they put Filipino doctors in this hospital. And the Indians tell me they don't want to go to "slant-eyes," so they come across the river to see us. So this makes a load for us.

You talk about satellite clinics. Creighton University put one in Tekamah, and it was run by P.A.'s. No offense to the P.A.'s. It was on a satellite basis, I think, like you're talking about with the Boone situation. But the people didn't go to the P.A.'s. They want a doctor.

Now, that's the sort of thing that brings a point up here I wanted to ask this banker, was if he had a P.A. here, would he go to him; or even if he had a G.P., would he go to him; or would he go to Sioux City to his specialist? Many of the small outlying towns close to a big city—a G.P. doesn't want to be just the on-call guy in the middle of the night. And that's the point that they—these kids aren't dumb that are coming out of school, and the reason I know it is we've had six or seven with us this summer, and they are smart kids and they can ask terrible questions. And they're a lot of fun.

Senator CLARK. Now, I asked that question of Howard, and he said he thought that the community would, given some time, adjust.

Dr. GARRED. That is what he thought, the community would. But ask him pointedly, would he do that?

Senator CLARK. Well, Howard, where are you?

Dr. GARRED. This is the point. This is the point, like with the Vietnam physicians. The town of Sloan asked me about a Vietnam physician one night. They had a meeting of their committee, and I asked each and every one of the committee, I said, "Would you go to the Vietnam doctor if he came here? You got to remember, if he comes, you're going to have to support him." Nobody would. So that's the point you have.

I got some points I'd like to make about remoteness. I don't believe that's a big factor. As you know, we're very versatile about getting around these days. You can always call up a neighborhood doctor, even if he's in the next county, and say, "Gee, I wonder what you think about this or that." And you got telephones, you got radios, you have cars and airplanes.

Senator CLARK. So you don't feel that the professional isolation is a problem, if any?

Dr. GARRED. I don't think it's an awful big problem. It's nice to have a guy to chew with in the next room a little bit, but I don't think it's that big if you're a little independent. I might give you a little history. I came to Whiting in 1946, and I'm one of the youngest guys in the county. I had the opportunity to go to more interesting places. For instance, I have spent 2 years in 1953 in Hawaii, and they tried to talk me into moving over there. But I came back to Iowa, to this country place. So you see, I am a little bit strange.

We've been trying to get doctors in our area, and we have a good hospital. We serve the area good, mainly because we've got just exactly like this doctor's situation. None of us are working in a clinic, but we work together well and we take calls for each other, and we get along quite well. We have had numerous students from our communities go to medical schools. They have not come back, and if you would like for me to expound on this reason, I can tell you a little bit. Some of it goes back to the word called—the phrase, “Ph. D.”

In Iowa City—and we call that our “ivory tower”—the Ph. D. gets the medical student first. In his formative years, in the beginning years, he's kind of looked down upon with the Ph. D. because he may be out here taking care of people in a few years and making more money than he is. That's a little paranoid feeling I have about it. So he tells these kids how inadequate they are, and they're scared when they come out of school. They're a little bit leery of trying to go out and dig it up themselves. And I think this hangs on to them.

Now, we have had a lot of kids in our area that come and they say, “Gee, this was a lot of fun out here in the country. We'd like to come back.” They go back to Iowa City, and in a few months, you hear about they are going to be a subspecialist in pathology or something like that, and they didn't get back. This is a bad thing.

Now, we think we have got it licked a little bit, because we have got three or four kids in med school right now, and two that are trying to get in. This is one of them here that's trying [indicating], and we think probably these kids will probably come back, because they're our local kids and they have been telling us they are going to come back. So we think maybe we've got some of the problems solved.

I'd like to bring out another point about fees. This doctor really brought out a lot of good points, and I want to enhance some of them. He really had it together today. One of them is on the medicare fees. I agree with him on it. Another point is about P.A.'s fees, for instance, for nursing home calls. In our area, there is a nursing home in Onawa and there is a nursing home in my town.

OK, that's 7 miles. If I drive to Onawa to see my patients in that nursing home, medicare allows me \$4 for the trip, the mileage, whether it's midnight, whatever it is. OK. If the doctor from Onawa drives up and sees one of his patients in the nursing home at Whiting, he's allowed \$4. Now, that's even less than an office call, and if they downgrade the fee because you have a P.A. making the call, you're going to have a tough time paying for the gasoline. So it's not hardly going to be worthwhile, anyhow.

Senator CLARK. Why would they pay only \$4?

Dr. GARRED. Beats me. It's like he says. It's the old custom of history, and this is the way. This was a representative of the State medical people. He might be able to tell you that in a minute.

Anyhow, I wanted to talk about that. One point that maybe wasn't clear, you asked about nurse practitioners. The nurse—as I understand, the nurse practitioner not only can take the P.A. boards, but they also have their own nursing boards that they take. So I wanted to bring that out. I think another big hazard is not—I don't think it's medical offices and stuff, but I do think that these gosh-awful malpractice premiums back the young doctors down from out in these areas.

Senator CLARK. Why would that be any worse in the rural areas than in the metropolitan?

Dr. GARRED. I don't think it is as bad, but it's bad. For instance, a lot of times now it's \$8,000 or \$10,000 and for you to pull \$8,000 or \$10,000 out of your hat for a malpractice fee when you think you might not make that much the first year you're starting—say you're a loner like me or he when we first started. If we had started out and we had to pull that out of our hat, we would have been hard pressed, and we wouldn't have done it, that's all.

But my son here, who has watched me over the year working in the small town and has decided that he thinks he'll try to go into medicine, I think he has some theories about getting some doctors from the medical schools to a small town, if you'd like to hear that.

Senator CLARK. Sure, be delighted to hear anything you might say. You'd like to go into medical school?

Mr. JOHN GARRED, Jr. Yes, sir.

Senator CLARK. What's your first name?

STATEMENT OF JOHN L. GARRED, JR., OMAHA, NEBR.

Mr. JOHN GARRED, Jr. I'm John. I'm a junior and he's a senior. I'd first like to state my case. I have applied to the University of Iowa 2 years in a row and have been turned down on the last cut every time, and I feel I'm as capable as any other student that would like to get into medical school. There have been different reasons mentioned why this has happened, and currently I'm working on a graduate degree in Creighton University, and they have seemed really receptive as far as medical school goes, and I'm very interested in their school, due to the fact that they push family practice. And they're very good in their clinical medicine, and I think maybe the University of Iowa can take some ideas from this.

Now, I don't know what your influence is, whether this is totally Federal or if it's State or exactly where you have to cut your lines, but one suggestion I would like to make, and that is that there are a lot of kids that want to get into medical school, good kids that want to get into medical school, and I would suggest that rather than increasing a lot of bureaucracy as far as having to set up clinics here and there and forcing people to work in them and making satellite communities and setting up satellite deals like this, I would suggest if you could in some way pour more money into your medical schools and possibly federally and from State funds, so that more people could be educated, you're going to be putting the primary care doctor out in the community.

Senator CLARK. But let me interrupt you there. That's always sort of been my thought, too. But as I looked back through the statistics, I found that we've doubled the number of students graduating from medical schools in Iowa and we haven't had—we have been going significantly downward in the number of physicians that go into rural areas.

Mr. JOHN GARRED, Jr. OK, but let me qualify this. I'm not completely done here. The stipulation being—and I know that the Federal Government has tried to do this as far as blacks are concerned. Nothing against blacks or anything, but medical schools are required to take so many blacks per whatever their student basis is that they're going to graduate, hoping that these blacks will go back to a ghetto and do whatever they are going to do in that ghetto to help the people. Well, why not do the same thing in the State of Iowa at the University of Iowa and say, "OK, we'll give 20, 30 physicians to kids that really want to go back and practice in a rural situation." And currently, that is not being done.

Senator CLARK. I might say, we did try to do that. Senator Kennedy was the originator of an amendment which I supported, but we simply could not get a majority of the Congress to support that concept. We had tremendous resistance from the various medical societies and associations for it, because they felt that we were, in effect, requiring a person to go against their own free will into an area. So that's a concept we tried, but it did not work.

Dr. GARRED. Change the philosophy of the Ph. D., though, so that he says to these guys, "Look what good you can do in these places," rather than, "Look what a terrible situation you're going to be in when you're out there and look at all the damage you might do because you're so stupid." See what I mean?

Senator CLARK. That the Ph. D.?

Dr. GARRED. Yeah. The doctors that are in charge of them, in their basic science—am I too much wrong in that, do you think, Doctor? Don't you think that if these kids were encouraged and there in the admissions committees and all these people would say, "Look you guys, you could do a lot of good out here"?

Senator CLARK. I think there is a trend in that, at least if you go down to the University of Iowa Medical School—

Dr. GARRED. They've changed a little bit, yes.

Senator CLARK [continuing]. And talk to the people there. But I'm interrupting you. Go ahead.

Mr. JOHN GARRED, Jr. Well, I'm still saying—I don't—your amendment, you know, I don't exactly know exactly what it entails. But you're not really forcing somebody to go to that environment if he wanted to go to that in the first place. I'm talking about having the admissions committee accept the person that would like to go back and practice in a rural situation. If he wants to go back to a rural situation where he thinks he can do some good and do some help, 9 times out of 10 you're going to have a higher probability of that person going back there than somebody that doesn't really care where he goes or doesn't really want to go there in the first place.

Senator CLARK. You're saying there on the admissions—

Mr. JOHN GARRED, Jr. Right.

Senator CLARK [continuing]. As a condition of admission?

Mr. JOHN GARRED, Jr. Right.

Senator CLARK. You have to go back to an underserved area to serve or you can't be admitted to a medical school?

Mr. JOHN GARRED, Jr. That's essentially what they're trying to do with the blacks right now, except, you know, I don't know how well it's working.

Senator CLARK. Well, we're not doing that with the blacks in medical schools.

Mr. JOHN GARRED, Jr. Well, I know, like, Creighton has to have 10 open positions for blacks for some reason to go back to, you know, hopefully going back to—

Senator CLARK. Yes. I think that's the point, the "hopefully." They're not required to.

Mr. JOHN GARRED, Jr. Yeah, right.

Senator CLARK. Thank you, very much. I appreciate your testimony. We have tried a number of carrot approaches to, so to speak, encourage medical students to go back to rural areas, and many of them having come from rural areas.

But needless to say in this State, many of these people who do not go back to rural areas are from rural areas. I mean, they come from a rural area. They go to medical school, but they don't go back to that rural area. Now, we've tried a number of sort of carrot approaches to encourage people to do it, but none of them seemed to work. And that's why we did finally last year resort to this amendment which you suggested; namely, that as a condition for giving so much Federal money to the medical schools and the scholarships, that people would be required to serve for a brief period of time in an underserved area, either in an urban ghetto or in a rural area. But that was opposed very, very vigorously by the medical profession and, I must say, by the majority of the Members of the Congress; and it was not made into law.

Dr. GARRED. I would like to tell you one more thing that was interesting, since John has been talking about Creighton. They have—and we were talking about remoteness—Creighton University, in their family practice department, has a program now where they are teaching—this is in relation to the outlying boondocks in Nebraska—their students that are in the family practice department and that want to do this, they're teaching them to fly, and they have a flying club, and these boys are learning how to fly so they aren't really remote. They can buzz into Denver or wherever they wish to go from Nebraska, so this is an interesting point.

Senator CLARK. Interesting idea. Anyone else?

STATEMENT OF THOMAS PETERSEN, JR., PRESIDENT, SIOUX VALLEY MEDICAL CENTER, ANTHON, IOWA

Mr. PETERSEN. I'm Tom Petersen from Anthon, Iowa.

Senator CLARK. Anthon. Good.

Mr. PETERSEN. And we have one of the Sears Foundation clinics. Sixteen years ago we built this, and we paid for it within our community. And we got a doctor out of the University of Iowa, a fine doctor, and he was there. He was killed within the last year in Texas.

We can get a doctor. I'm in contact with a lot of doctors. Friday night I was in contact with one from Hillsboro, Tex.; wanted to go

solo, family problems, wanted to get away from a former wife. You run into these kinds of things. But we can get a doctor. Interviewed one about 6 weeks ago from Creighton University that you're talking about—has a real fine situation. This doctor is from Bolivia. He has been in this country for 22 years, and he took his training in Mexico. He wanted to become a doctor after he came out of service, but he was at the age a year too old, so he went to Mexico to get it. Then he went to Toronto to internship.

He is back here. He has been trying to take this foreign doctors exam, I believe it is. He married a Boone girl, a registered nurse and a fine lady, and he's a fine man. And this examination—he would just love to take the medical examination, but he's got to pass the first exam first, which doesn't have anything to do with medication. For example, "What is the cause of so many car accidents in New York City?" is one of the questions that was asked of him. I couldn't answer it. Too many cars, too many people, I don't know. But this is one of the questions that were asked and that he failed by two or three. Now, this man would come to our community now, and he is a fine man, and this is one of the things.

And we went to see Dr. Hamm with this gentleman to see if there was some way—you're talking about physician's assistants—that he could work under. And I agree with you, Doctor, on the physician's assistants within your practice rather than satellite. I think that he can do you more good where he's at. I have been in this thing for 16 years, in this medical thing, and I have seen a lot of things and contacted a lot of doctors. Health Planning Council in Sioux City, I've attended a lot.

And you talk about your satellite as the doctor's solo. This doctor was there alone that we had, and you train your people like you used to when you had the grocery stores running on Saturday night and Sunday morning. That doctor, you don't get sick so many days, but if people just had a slight headache or something, they didn't call him like they would otherwise. He set up to go on vacation. He put a notice in, and this was taken care of. People expected this, because you can't work 7 days a week, and people respected him for this. It was a beautiful situation. It was all—

Senator CLARK. You feel you would be able to get a doctor?

Mr. PETERSEN. Yes, I do; but you got to work. You got to work at it. You have to work hard.

Senator CLARK. What about these 160 communities that say they need one and have been looking and can't find one? What should they do?

Mr. PETERSEN. We're in the National Health Service Corps. We have been in there for some time. We're in the National Search, and I get calls about every Friday evening from Los Angeles, Calif., in regards to Search. And Search is working, because in Avoca, Iowa—I was there early this spring. They have one from National Health Service. They put up so much money with this situation. We did, too, and we have had a lot of calls. But they have got a Filipino in there, mentioning Filipinos. It's a town of 1,800, haven't had a doctor for 10, 12 years. And his only wish was that they would guarantee him \$3,000 for 90 days. He says to this day he hasn't come after any money. The president of the bank told me, "I think everybody went

to see him." And he said, "I never got a finer physical than I did from this Filipino."

Senator CLARK. All right. Any other comments?

Dr. GARRED. I hope you get one so it will take some of the load off us.

Mr. PETERSEN. But this is the comment that he made.

STATEMENT OF FLOYD BLADES, MOVILLE, IOWA

Mr. BLADES. My name is Floyd Blades. I live here in Moville at this time. I haven't lived here very long. I just retired this year, but what I wanted to talk about was just a little bit different from the questions.

Senator CLARK. Fine.

Mr. BLADES. This country has been in existence now 200 years. We started out with a few people in a little portion of the United States, and everything, all everything had to do was grow. Every part of our society, our Government, it was made up and set out by a few people that were there, all the people, you might say, and it's about the only Nation with one form of Government that has survived 200 years. We think we're new, but we're not. But during that time, they had to set up everything, school systems, commercial systems, agriculture systems and industry, and everything had to be done starting from where they were.

Now, I was born and raised down at Mapleton or near Mapleton, but 70 miles west, which is only 35 miles from here, we had a doctor from Marshalltown. Mapleton was just a small town, just a little smaller than it is now. Dr. Guillespie was there, and he was the family doctor for everybody within 15 miles, and he had a pretty good top buggy and his horse and his bag of medical supplies. He took care of all of us. He brought me into the world, my sister and brother and my children, and so forth. He was a family doctor.

Well, after he reached maturity quite a long while later, he moved to Sioux City and specialized there in Sioux City, and is a surgeon and is a very good doctor. But as other things of our society grew and found ways to grow and develop differently—like, in 1929 and 1930 we had to develop a complete new commercial system, banks and everything. Agriculture was in a bad way because it doesn't move, from Kansas to the Mississippi River. We had to learn how to do it. And the President, in his fireside chat, would say, "We can do all of this, but, of course, we'll do it on a couple dollars a day. But we'll do it." And we did.

And there was more progress in almost all phases during the thirties in the time of the Depression and the droughts than we had in any other 10-year period. Industrially, we built all the dams on the Missouri River and the Colorado and the Tennessee, and we set up a whole system of electricity for all over the United States, and we fought the drought period by putting up timber belts and setting up contour farming and all of those things. We got those things done. And, of course, at the end of the thirties came war, and then things changed a lot differently.

But the people had done these things with their hands. But there was one thing that dragged behind, and that was the medical system.

The country doctor was expected that he keep riding that dappled gray horse for the next 30 years and get the job done. But they found they couldn't. So there is a silent force that gets things done, and they began setting up big hospitals, spending millions of dollars in a city of the size of Sioux City. They have got a big medical deal there, but those three big hospitals spent from \$3 to \$8 million apiece to get it. And they spent a like amount on facilities to use in that hospital. So we can't say that if we do something just a little bit different that we'll get all the medical assistance we want if we don't have any bounty to offer.

But they do in the city, Iowa City, and the little town up here in Minnesota, Rochester, and Sioux City ranks pretty high among all of them for the population and everything. They have got the facilities and the matter is, they can use them. Well, at the same time, the people have had ways and means of traveling and they could get to Sioux City from here a lot quicker than they could have got 5 miles to Mapleton to where I was.

But they didn't have to go. The doctor came. They had home service and they got these things done, because it was needed. Now, in a commercial system I want to draw a little bit on that. They built banks in the cities like Sioux City and all, \$3 or \$4 or \$5 million each on this street and this street and that street and that street, and to solve the problem out here in these small towns that we're talking about each bank put an office in the small towns. Smithland or Sheldon has a bank, but I think they have offices and other banks. Sioux City has offices in the smaller banks, and out here they call them banks, and they are. But they're under the auspices and under the capital financing by the big banks.

Senator CLARK. Yes.

Mr. BLADES. Well, now, we have talked today about other ways of trying to get people a little closer to their doctor or the doctor a little closer to his people, and they've established clinics in some of the smaller towns where they have two or three doctors and facilities for them to go there and get some service. And there is a possibility that they could have mobile clinics. Now, this is something a little bit different than we have been talking about today, but it would cost more than a thousand dollars. They'll have to have the facilities in the hands of the doctors that are doing the work; and if they have a mobile unit that can go and contact, say, 10 of these rural communities on given days so that they can get the service to the people, then it's not going to cost any more than it would cost to build a hospital.

So if we can think of some way, as we are trying to, to get the medical facilities to the people, and especially the overage and the underage and people who can't supply it themselves, there might be a way, and I still say it's a force in the darkness, because you can't lay out describing something that isn't here yet. But I thought maybe that if we would think a little bit on some of the practical lines and some of the ways that everything—like, they're having a World Series in some place in the United States today where there will be millions of dollars spent to see it. This is also a sandlot ball game someplace in your small town.

Senator CLARK. That's an interesting comparison, and I appreciate very much having your comments. Excellent.

STATEMENT OF LAWRENCE L. WHITE, JR., ASSOCIATE ADMINISTRATOR, ST. JOSEPH MERCY HOSPITAL, SIOUX CITY, IOWA

Mr. WHITE. Senator Clark, I'm Larry White. I'm from Sioux City. Quite a number of your witnesses have spoken to the importance of the family practice residency program, and I think that that needs to be underscored particularly. It, to my knowledge, has not been in existence more than 5 or 6 years in the form that we see it today, that being a residency which is being conducted outside of the ivory tower of the University Medical Center. One such residency program has been started in Sioux City, Iowa, and we presently have our first-year residents. We have 5 residents presently and will grow to a maximum of between 12 and 18 in the next 3 years.

The reason I bring this up is because I think it is really one of the ongoing, important devices for putting physician manpower into rural areas. There are many studies that have been done about physician recruiting and replacement. One of the most consistent statistics shows that physicians tend to locate in the area where they last did their training. My point is—something of an editorial for the program in Sioux City—it is the only program west of Des Moines in the State of Iowa, and it is presently undergoing some rather serious financial difficulties through two vagaries of the funding system. One is through the State, where the appropriations bill, I believe, was extended only for existing programs that were up and running prior to 1976. Since ours started in 1976, we have not been funded through the State legislature. That leaves the financial burden to be borne exclusively by the three Sioux City hospitals that formed this residency program, and it runs to the tune of \$200,000 or more per year.

The second vagary that hurts is the fact that medicare and medicaid reimbursements to hospitals are beginning to cut off reimbursement for education programs that are not owned and operated expressly by that hospital. And indeed, the Sioux City residency program is a separate, free-standing corporation which is not directly tied to any of the three Sioux City hospitals. It's a consortium that was formed by them and is a separate corporation, and the costs incurred by the hospitals in sponsoring this residency program are being threatened with nonreimbursement by medicare. We think that these kinds of problems can be overcome, but they're going to give us some growing pains in order to manifest destiny sooner, rather than later.

Senator CLARK. Well, it's a good statement and I think you're right in saying that this is a part of the answer, that the family practice residency is important to encourage. Obviously, we have no assurance that these people, as they come out, will go to rural areas, but I must say that the University of Iowa's figures, for example, in their family practice residence this year, they graduated 24 and 15 of those did indeed go into rural areas.

So I think that's compared to any statistics we have had in recent years, that's encouraging, and I think you're absolutely right in saying that this is a good program that we should be expanding in places like the Sioux City program. And I think if that's an area where the Federal Government could be of assistance, in terms of making sure that the funding is adequate for these family practice residences, I think you're absolutely right.

Other comments? Yes, sir.

**STATEMENT OF EDWARD BEACOM, PROFESSIONAL RELATIONS,
BLUE SHIELD OF IOWA AND IOWA MEDICAL SOCIETY, SIOUX
CITY, IOWA**

Mr. BEACOM. I'm Ed Beacom from Sioux City. I have comments just briefly on a couple of things about reimbursement by Federal programs.

Senator CLARK. Good.

Mr. BEACOM. First of all, I think the statement was made that the rural areas are not compared to the urban areas, but that really is not the case in Iowa.

Senator CLARK. They were? I didn't understand you.

Mr. BEACOM. They were saying, as far as payments are arrived at, that rural areas were not included with the urban areas. But in Iowa, for example, for medicare title 19 and CHAMPUS programs, areas are based on the old congressional districts, so that Fort Dodge and Sioux City, for example, would be included with Sheldon.

Now, it is by specialty, but family practitioners throughout north-west Iowa would be compared for purposes of fees. The reason doctors aren't getting their fees allowed is because there is such a lapse in time between when a doctor increases his charge and when these various programs recognize his new charge. That's the primary reason why most doctors under these programs are finding that each year a lesser and lesser percentage of their fee is being paid. However, the other part of it is comparing what is reimbursed here in Iowa, compared to, say, to what is reimbursed in California or New York. Is there justification, for example, for reimbursing somebody in California three times what a physician is reimbursed in Iowa; and does that, in fact, contribute to the fact that there are more physicians than they need out there, but fewer physicians than we need back here? And the Government is, in effect, causing this situation to continue to exist by reimbursing them three times as much for the same thing out there.

Senator CLARK. Do you think it's possible that they are reimbursed three times as much—

Mr. BEACOM. Yes; because out there—

Senator CLARK [continuing]. As in rural areas?

Mr. BEACOM. Yes; because, if you have more physicians than medically necessary in an area because it is such a desirable area to them for one reason or the other, then rather than causing the fees to go down, they're increased. For example, a general surgeon in California will perform far fewer surgeries than if he practiced where he is needed. But he wants to make as much money out there as he would make back here, so he charges three times as much, because he is only doing one-third as many appendectomies or whatever.

So presently medicare and title XIX are paying on the basis of what the local fees are—even though they're paying on what local fees were 2 years ago. They're still falling in line with what has historically been true, that physicians in California charge three times as much as physicians do in Iowa.

Senator CLARK. It's helpful to know.

Mr. BEACOM. The other point I wanted to clarify, you asked Dr. Garred why there was only a \$4 reimbursement for a nursing home

call. Well, the reason for that—I think that may be changed now, because medicare, just October 11 of this year, updated their fees to what was being charged back in 1975. But anyway, the nursing home call, unless they specifically go just to see one patient there, is paid at the same rate as what would be paid for a routine office visit. Now, if they go to a nursing home and see only one patient, and that's shown on the claim form, then they get paid at the same rate as they would for a house call.

And finally, if it's a nursing home out of town, for several years medicare and title 19 could not reimburse anything additional for their travel out of town. They would if they went to a person's home, but they wouldn't if they went to a nursing home. This has been changed, again, so that the regulations permit, if a doctor goes out of town to a nursing home, that he could charge a mileage rate for one of those patients.

Senator CLARK. Those are good responses, again, very helpful. Anyone else have anything to say? Yes.

STATEMENT OF HON. DONALD PAULIN, MAYOR, CITY OF LE MARS, IOWA

Mr. PAULIN. I'm Don Paulin, mayor of LeMars, and I'd like to comment just briefly on LeMars' situation. Our ratio of residents over the age of 60, by the way, was 17.1 in 1973, which is very comparable with northwest Iowa. I don't see any trend to where that has changed in the last 3 years. A year ago, the Floyd Valley Hospital area, which comes as LeMars, Remsen and five other smaller towns, approximately 15,000 people, had seven physicians.

Senator CLARK. How long ago?

Mr. PAULIN. A year ago. Of those seven, though, five were of retirement age or very near so. Today we have five, and three still, of course, are of retirement age and they are definitely retirement age and certainly would if they didn't feel a moral obligation to continue. So in effect, we are down to two. We have a \$2 million hospital, and as I said before, 15,000 people, and we view the family service practitioner plan from Sioux City as a hope. That's a gleam of hope.

And to hear today for the first time that we need to contact our legislators to urge a continued funding is a sort of a slash at that hope. So I certainly hope that that doesn't develop to be a major problem, because we did think, and certainly agreed, that where they last practiced is where they might land. And we thought that this was a great hope. We would like to urge a continuance of that program, as well as others that do what other people have testified here today, bringing it down to a local level.

Senator CLARK. Good. Thank you, very much. Anyone else want to say anything? If not, we thank you, very much, for coming. I do. Incidentally, I want to thank Marv Parker for what he has done in the past for arranging the sound system here, and Nancy Parker and Norma and Lyle Scheelhaase for their help in arranging these hearings, and Jim Dorn for allowing us to use the Legion Hall, and to all of you for coming, particularly those of you who came a distance to testify. It's been very helpful to us, and thank you, very much.

[Whereupon at 5 p.m., the subcommittee recessed, to reconvene at 10 a.m., in the First Community Bank Building, Traer, Iowa.]

RURAL HEALTH SERVICES IN IOWA

MONDAY, OCTOBER 18, 1976

U.S. SENATE,
SUBCOMMITTEE ON RURAL DEVELOPMENT
OF THE COMMITTEE ON AGRICULTURE AND FORESTRY,
Traer, Iowa.

The subcommittee met, pursuant to notice, at 10 a.m. in the First Community Bank Building, Hon. Dick Clark (chairman of the subcommittee) presiding.

Present: Senator Clark.

STATEMENT OF HON. DICK CLARK, A U.S. SENATOR FROM IOWA— Resumed

Senator CLARK. The hearing will come to order.

I want to welcome you to this hearing of the Subcommittee on Rural Development of the Senate Committee on Agriculture and Forestry. I think that if this hearing is anything like the three hearings that we have already held around the State that we will go away with a good bit more knowledge than we had when we came.

In this particular hearing we are looking at something all together different; namely, how the National Health Service Corp, a Federal program, really can affect health service in a small community.

Now, I might say, these hearings are an attempt to really get a better picture of what is happening in rural health care in Iowa. These hearings, generally, are connected with visits to a number of health clinics just as we looked at the one this morning here in Traer and have looked at others in Madrid and Melbourne and other parts of the State. We are going to be ongoing from here on down to Cedar Rapids to talk to people in family practice residencies at the two hospitals down there and then on down to Mechanicsville later this afternoon to look as some satellite clinics that are operated in connection with family practice in Mount Mercy and Saint Luke's Hospitals.

The idea of these hearings of the subcommittee is simply to study the problems of rural America generally to see most specifically how health care problems are being addressed in this State and across the country. In fact, last February, Senator Leahy of Vermont, who served on this committee with me, chaired a series of rural health hearings up in his area up in Vermont and we learned a good deal there. We learned, for example, of the rather special circumstances of people who live in rural areas in New England. But we also learned a good bit about the whole problem of rural health care.

We found two things in particular that were a problem that we began to address ourselves to, certainly, after these hearings.

I say this really by way of introduction to the hearings that we are holding today.

We found first that one of the reasons we are not able to use I guess what we could call health personnel, physician's assistants, and nurse practitioners was that they are not reimbursed under medicare and medicaid, and that's one of the great problems.

We went back, so far unsuccessfully, to try to pass legislation to do that. The other thing we did was to introduce legislation. In fact, I had an amendment passed about 2 months ago which provided long-term low-interest loans to build clinics, clinics such as this one that has just been constructed in Traer and in many other parts of the country.

In fact, the legislation that I had also had some grant money and it passed the Senate with grant money in it, but the House refused to accept the grant money so we are at a point where we have only long-term low-interest loans. But we think that can be helpful for the community as well so we are looking for ideas of that kind such as came out of the Vermont hearing so that we can go back with it. And as we go back into session in January, hopefully have some ideas on what we can do based on the Iowa census in communities like Traer and Mechanicsville and others that we are visiting to see whether in fact they found some interesting and more important, some valuable ways to extend health care into smaller communities.

Now, we are in Iowa this month to assess the special needs and problems of this area. Next we, the subcommittee, are going to be conducting similar hearings in Appalachia and through many of the Southern States so we will have a national investigation of health care delivery throughout rural America.

Our goal is to return to Washington with some concrete proposals to fulfill the promises of providing adequate health care services to all Americans whether we live in the most affluent suburbs or the smallest community.

Now, we felt that these objectives probably won't be met without getting a good deal of input from people who are themselves concerned and interested and working in that problem. I mean particularly the physicians, but also nurse practitioners, physician's assistants, people like Dick Dahms, Cecilia and Pam Woods. We mean people that we are going to hear from today who themselves have a very direct knowledge, may not be physicians or may not be nurse practitioners, but who work very directly in that problem of trying to find physicians and in the problem of trying to bring health care, to extend health care, from the larger communities into some of the smaller communities.

When I say smaller communities, I'm really talking about communities of under 10,000. In fact, the jurisdiction of this subcommittee is limited to communities of 10,000 or less.

So that's the reason we are here, to try to listen and learn from people who have been very closely involved with it. Our Nation obviously has spent several hundred million dollars in the past few years to encourage health professionals to practice in medically underserved areas. However, that effort has not been successful.

Now, Traer seems to be an exception to that recently, but the vast

majority of communities in this State and across the country that are this size simply have not been successful at getting a physician. And the longer one looks at the problem, the more it seems that it is going to be unlikely that every small community is going to have a physician.

In Iowa alone now there is something like 160 different communities that are separately looking for physicians. Some people told us at one time, "Well, the answer is just to have to graduate more people from medical school." But the fact is that we are graduating twice as many people from medical school now as we did 10 or 15 years ago. And yet we have fewer and fewer physicians in rural areas, so it has to be something more than just more physicians. It has to be family practice and it has to be some other kind of arrangement than simply the arrangement that we have had through the century or more particularly, through the last few decades.

I came from a town of about 490, I think, when we're all there. We had a physician until the Second World War and finally he got very old and eventually died maybe in 1946 or 1947. And most communities did have a physician at that time. But at least if we can believe the testimony that we have had before this subcommittee, the fact is that that arrangement has changed. The whole idea and facility and quality of health care has changed and as a result, we have got to look, I think, at some new ways of arranging our system in terms of medical care so that we really do have some kind of physician's help and physician's extenders into every area of the country.

Now, obviously, it isn't just a question of getting a doctor in every community. It isn't just a question of a certain number of doctors in every county. There is nothing magic about a city limit. There is nothing magic about a county limit. But the maldistribution out of the rural areas as a whole is what is much more disturbing than the particular community or the particular county.

We are going to be releasing some figures tomorrow, if we can verify them today, which show, indeed, that although we have more family practitioners now in Iowa coming out of medical schools or residency programs, but that is continued right on down through this year of fewer and fewer physicians coming to rural areas.

And we know right now, for example, in Iowa that half of all the physicians in this State are in just six counties. Again as I say, it is just not a county line question so that may not be the best way of expressing it, but it gives you a picture generally of the heavy concentration in some of the metropolitan areas. I might say, too, some of the metropolitan areas have shortages such as Sioux City. But basically it's just not a very good concentration. It's not a very good distribution in terms of providing quality care in centers that can at least themselves provide some kind of care out into the rural areas.

We know, for example, that the national average of doctor/patient ratio is about 750 to 1. Every doctor in this country has about 750 patients. I think the exact figure is 763 if I remember right. This is general care practitioners not specialists. One to 763. In Iowa, it's 1,000 to 2,500. And if you look at the national statistics, generally you find that cities of more than 5 million take the highest category that has been looked at. That is one physician per 500 people. But if you look in communities all across this country at 10,000 and less, it is 1,000 to 2,500. That means on an average a physician in a community

of less than 10,000 serves five times as many patients as in the larger cities. So you begin to see something. These are all just sort of ball-park figures, but they give you some concept of the nature of the maldistribution of health personnel, and of course, it is in just physicians.

It's the same kind of maldistribution in almost every area of medical care, so that is what these hearings are really all about, to try to listen to some people that are working on it, I think, that have found some answers in the case we have; and to see whether the Federal Government has any role to play in this and if we do, what the role should be.

As I said, we, of course, this morning are starting with a rather unique case here in Traer because we have, in fact, gone through the effort and the successful effort of building a clinic, attracting doctors, and attracting in this case National Health Service Corps physicians.

Now, we have been putting a lot of effort in that National Health Service Corps, and in fact, this year just have authorized significantly more funds for this program. Right now we are funding, I think, only about \$10 million in appropriations—\$15 million, yes, I'm sorry—\$15 million in appropriations and we have significantly increased that for next year in an authorization.

Now, that assumes we are going to appropriate for it. We are confident that we are going to pay at least \$25 million so we are very anxious to see how this is working. This would mean that we could almost double the National Health Service Corps funding and physician's extenders if we are able to get the appropriation for these programs. Briefly put, it is simply a program in which the Federal Government pays the scholarship programs for doctors in medical school in return for serving in underserved areas whether these are urban ghettos or rural areas.

Well, there will be a lot of other things to say about this and a lot of other comments, I'm sure. But let's just start with that and I know that Dr. Downie is hard at work. He's on an emergency call so we are going to start without him which only proves that this system is working, I maintain. So—

Ms. PODHAJSKY. We've got a lot of sick people.

Senator CLARK. That's right. So why don't you start, Cecilia. And I know you have been very active here in Traer in terms of the whole question of health care. So why don't you just proceed in any way you think appropriate in terms of what you think happened here. Are you prepared to do that? Talk about it and then we will go through all three witnesses. Then I'll have questions. I've got some questions

STATEMENT OF CECILIA ANN PODHAJSKY, PRESIDENT, NORTH TAMA MEDICAL ASSOCIATES, TRAER, IOWA

Ms. PODHAJSKY. Well, basically, the NHSC program. We got involved in it rather suddenly and it just moved right along for us.

Senator CLARK. By NHSC you mean National Health Service Corps.

Ms. PODHAJSKY. Yes. And everything just seemed to roll right along. We acquired physicians, seemed rather easily. And we were able to get a clinic established and built in a very short time period. The whole program in general is a very good program for the fact that young physicians coming out of medical school or just after coming

out of medical school and they have not had a business background. It's very helpful for them, this program is, because if they sign up on a 2-year period and so for 2 years they are not really responsible for the business end of the practice. The community is.

On the other hand, you get people involved from the community who have a fairly good knowledge of business and they leave the medical end to the physicians and the physicians leave the people to take care of the business end. And in the meantime, the physicians are supposedly learning about the business so that after a period of 2 years they will be much better qualified to run and maintain their own business practice.

This is a very good idea and we acquired physicians rather easily. It's very good although no one really knows until they are in the position of having to financially run the clinic the problems that can arise out of the program. Just little things that you are not—from the very beginning the way things are told you and as they turn out are different.

We were told that we would have options as to how to reimburse the Government for the—the Government pays the salaries through the program of the physicians and then we are to pay back a percentage of the salaries depending on how the practice goes. And I received a letter here a couple months ago that said that after five quarters of practice that we are—it's mandatory that we are to pay back the full salaries of the physicians to the Government.

It's almost an impossibility to do just starting off the bat when you are financing a new clinic and this type of thing. We've never received a satisfactory answer on why this was brought up now at this time.

Senator CLARK. You felt that they were going to reimburse you indefinitely?

Ms. PODHAJSKY. No. We felt that we had an option as depending on how the practice was financially running. Each month we sent in monthly reports and then a certain percentage you can deduct.

There is definite categories that you can deduct. And then the balance that you pay back is a certain percentage of what you have taken in. But then we were told that we had to reimburse the total salary to the Government after five quarters of the physician being there.

We don't receive any financial aid from the Government but the physician's salary is paid for the first 2 years. But we were told that we have to more or less be paying the physician's salary after five quarters. And if we can't pay it, the Government has the option of removing the physicians from your clinic and these kind of things that put you in a kind of a financial bind because you can only generate—I mean, it takes a matter of time especially when you have not had a physician in the area to generate business and get a full practice going so that he can be self-sufficient.

And this is kind of what they have done. They first told you that you had 2 years and now they've put you up to five quarters of maintaining the physicians and total expenses of the practice.

Senator CLARK. Before you leave the subject—I don't want to interrupt you because I would like to hear the whole testimony first; but in other words, it was your understanding that the Health Services Corps would provide the full salaries of the physicians for 24 months

and now the information you have is that they would pay for only 15 months?

Ms. PODHAJSKY. Right; for five quarters.

Senator CLARK. And then will they pay a declining percentage of the salary?

Ms. PODHAJSKY. They way that the letter read is that we are to reimburse the total salary.

Senator CLARK. Maybe we could take a look at that after the hearing. I might just point out that about 1 month ago or a little less we passed a new health manpower legislation which provided for two or three things. But in this connection it allows HEW to waive requirements that communities contribute to the cost of paying salaries for Corps personnel and other courses. So that new legislation may affect that.

Ms. PODHAJSKY. There is a lack of communication somewhere along the line because we can call down to Kansas City where we call and if one person is out of the office they say you can talk to another one. And we get completely different answers when we call.

Senator CLARK. Well, I'm sure that this won't be in regulation yet. It probably was not signed into law more than 2 weeks ago so they won't know about it.

Ms. PODHAJSKY. Another problem that we have run into is collecting medicare payments. We cannot collect medicare payments from patients. We have to collect it strictly from medicare; and therefore, we are only collecting, I think it's even two-thirds like out of a \$9 office call which is standard around the area. We only collect a little over \$5 of it and all these things, just constant little things add up to a financial burden that small communities can't—it's awfully hard for them to carry. But the program itself, the concept of the program is a fantastic program.

The idea of the Government supplying—or more or less supplying because they are paying the salaries of the physicians and the community's responsibility with the clinic. But it gets all the more deeply involved than just, you know, we'll pay the physicians' salaries and you put up the clinic and that's all there is to it. There is a lot of little things, forms that you're supposed to fill out and send to the Government but they never send you the forms to fill out. Just little stuff like that.

Senator CLARK. Bureaucratic problems?

Ms. PODHAJSKY. Right.

Senator CLARK. Can you talk a little more about the concept. You say you think that it is a good idea. Why so? What experience did you have before this and so forth?

Ms. PODHAJSKY. For one thing, the experience of recruiting physicians from the community as far as going through your State medical societies and paying their expenses to come and visit your community through the National Health Service Corps. They pay the physician's expense to come to your community which right there alleviates some financial burden on the community. And it seems like it's hard for individual communities to come in contact with physicians. It's much easier with the Government help because they have screened the physicians and they know what areas these physicians are interested in going. Whereas by doing it individually as a community you might be contacting someone who they have no idea what your

area is like. And you go to a lot of time and expense to get them there and they are completely disinterested in your area. And you eliminate a lot of that. And like I said before, I think it's a great help to young physicians out of school who have had just medical training and no business training. It is a help for them and it's vice versa help for the community.

Basically, I mean outside of the little bureaucratic problems which they may sound little but when you're responsible for them, they're not so little.

Senator CLARK. Now, what is your exact relationship to the clinic?

Ms. PODHAJSKY. I'm president of the North Tama Medical Associates which is a nonprofit organization which built the clinic.

Senator CLARK. Yes.

Ms. PODHAJSKY. And we maintain the clinic.

Senator CLARK. Good. Well, I've got a number of questions about it, but let's go on and hear Richard Dahms and then Dr. Downie.

STATEMENT OF RICHARD L. DAHMS, TRAER, IOWA

Mr. DAHMS. I didn't have too much to do with the recruiting of the doctors and I hope I am qualified to give some good answers here today. I've got a couple of questions that I just don't know the answers to.

What has been the increase in graduates from the University of Iowa in the last 10 years or 20 years?

Senator CLARK. Well, somebody in the audience is probably better prepared to answer that than I am, but I think they have gone from about 100 to 200 graduates over the last 15 years.

Mr. DAHMS. In other words, there has been a mass exodus from the State of Iowa of qualified physicians?

Senator CLARK. Well, I'm not sure of those statistics, but certainly there has been as far as rural areas are concerned which is what we are looking at.

Mr. DAHMS. The agricultural areas of Iowa then have subsidized the University of Iowa medical graduates that have moved out from the State of Iowa then on to more lucrative areas; right?

Senator CLARK. Well, that's exactly what I was saying I am not sure of. I'm sure that they have in terms of rural areas of Iowa. Now, whether there has been more physicians who left the State than graduates, I've never looked at those statistics.

Mr. DAHMS. I think this would be an interesting thing to look into. I think that probably—

Senator CLARK. I guess we don't have those statistics but certainly in rural areas there is no question.

Mr. DAHMS. It's interesting because I can remember, and I hate to say how many years ago because I can remember when there were three physicians in Traer and three dentists. I think probably we're 180 degrees opposed to each other on solutions of problems in regard to health care.

Senator CLARK. We would be happy to hear your views.

Mr. DAHMS. I think that the State of Iowa and the local communities are capable of getting doctors. I don't think we need any more Federal help. I think we've got about all that we can stand. And probably you can give me some insights into this too.

There is a lot of talk around now and this would go hand in hand with what we are talking about—doctors. I'm not sure whether the Federal Government should have anything to do with it or not. In fact, I know they shouldn't.

There is going to be a push by Congress, certain Members now, that we are going to have national health care. And I think what I'm saying is that if you like the Postal Service, if you like social security, then you're going to love national health care because it's just going to go way out of line. I don't think we can stand it. But I think there are resources enough in this State and in this community, our community probably. There is two people turned down for every one application for the University of Iowa. I think these facilities ought to be expanded and also that they have to practice within the State of Iowa in a designated area for 4 or 5 years.

Why not? The taxpayers of the State of Iowa are subsidizing the University of Iowa; right?

Senator CLARK. I should think so.

Mr. DAHMS. Well, that's about all I have to say. If you have some questions—

Senator CLARK. I will have some questions. Dr. Downie.

STATEMENT OF ROBERT DOWNIE, M.D., TRAER CLINIC, TRAER, IOWA

Dr. DOWNIE. Well, I was going to talk on some other things, but I think where the tendency of the hearing is going, I'll just make my own feelings about some of the things that Dick brought up and I do agree with him.

I'm against nationalized health care and that is why I think this program has a benefit. I think it is tough for small communities to get even to be noticed that they want a doctor. I mean, I look through journals which is one way you do it or even a number of things that are produced by the medical societies across the country, county medical societies, State and whatnot. You very seldom see a place like this that you don't have to spend your own money to go and see.

Well, automatically you might be interested in it, but you're not going to take the chance to go there. So the program in allowing you to see the place and talk with the people and have some time there is valuable. The value in having the Government recruit then is that they can do it really on a national scale in order to be able to make doctors aware of which areas are available.

The benefit then to the program is that it is initially Government supported but the limitations of that really in most areas that we're talking about in the Midwest say this area are the idea is to have the doctor eventually have his own practice there and to pay back the community and so forth, for the clinic.

And that idea is nice because it takes it out of Government controlling national health care and it is really providing a physician for an area to eventually establish himself in an area that otherwise might have a time being noticed that they need a doctor. And that is the benefit of the program.

Where the program is broken down since I've been here and I think that is what Cecilia is meaning is that it turns out that it is not as it's painted to be. And the Government is wanting the money back. Well,

that's fine if that's the way it is billed when you are told about it. Then you know those game rules, but to have these rules be supposedly there and never be brought on the ground is upsetting. So I guess that I'm saying that I like the plan. I think the plan needs to be better regulated. That instead of spending so much money on national health care that a deliberate attitude of trying to go out and recruit people for rural communities would be set up ideally without the hooks in it that Cecilia has mentioned would be a good way to do it.

There are other things that I could talk about. I think the one question that I'll just answer to Dick is, I think, the problem is, of course, getting doctors to rural areas, is getting them to know what's there and getting them enough time to find out what the area is like. And then number two, medicine is becoming more and more specialized. Therefore, it means bigger and bigger cities in order to practice that special education and there is less emphasis by doctors to want to stay and try to be a general practitioner or a broad category family practitioner because the mass of knowledge in medicine is becoming so great it is tough to stay on top of everything across the board and do a good job at it.

Senator CLARK. I think—let me start with some questions with you, Dr. Downie. Can you talk a little about how you got into the National Health Service Corps? Why did you get into it? What is the program?

Dr. DOWNIE. OK. Can I give—well, I'll try to, as I go through, to give you steps as it was.

I think this is important for you seeing what we are objecting to. I'll give what it was presented to me as and as what it has turned out to be.

Senator CLARK. And primarily, just what it is.

Dr. DOWNIE. Well, National Health Service—I'm not sure the number of years ago that it was set up, but it is a branch of public health service. But the reason it was set up primarily is to set up a recruiting practice so to get physicians into smaller communities, that is, if you will, to get the smaller communities a source of advertising that they needed doctors.

And so the initial way that I got into it from that was what you are getting ready to finish. Your program had a number of pamphlets out and this happened to be another one. And myself and another friend of mine were going to go out and practice. And so we got out the letter and there was a big conference down in Atlanta. They would fly us then and explain what it was about.

Well, all three of us were interested in it and so we flew down there and we went to this conference. The conference—we had this 10 different districts that the country is divided into across the Nation. I mean, 10 different areas, the recruiting districts. You know, they have separate people in charge with each one. And you talk with the different people there and found out what places were available.

After that then it was a matter of really listing what preferences were, listing the size city you wanted, the category of how close do you have to have the facilities and all these kinds of thing. And then they try to match you up through a computer. It turned out pretty much that this conference gave me a number of three opportunities in the local area.

I looked at some other areas, the west coast and the Atlantic coast and then we had some friends out here and some family out here pri-

marily so we decided it would be interesting to see what was available in Iowa. And we did. We came out, I guess, back in November. No; it must have been January. It was cold. January, and when we came out in January we went to three towns. We went to Traer, Toledo and Parkersburg.

And in each town there were committees in charge of recruiting the doctor or that were working with the National Health Service and for various reasons we chose Traer.

For my own thoughts, that would be another category of why I chose it. What was my understanding—

Senator CLARK. Now, before we go to that, I think it is good for us to have all of these things on the record too. In other words, you had no commitment to the National Health Service at any facet of your education. It was simply a question of getting into that program when it came time for finding a location to settle in. It was kind of matching you with a locality.

Dr. DOWNIE. Right. I think the important question is why did I choose that as to going out and doing private practice.

Senator CLARK. Exactly.

Dr. DOWNIE. It would take a considerable amount of time, but California has gotten so insurance oriented and so malpractice oriented but patients didn't get good care really. They get to a lot of laboratory tests, they get a doctor or doctors that says to himself, "How can I make sure I don't mess up on this case so the person doesn't sue me?" Instead of, "How can I help the patient?"

It's getting that way in California and they are tended that way. That way their immediate response was, "How much can I help the patient but don't mess up because I don't want to be in a lawsuit." But it didn't really have to do with whether their messing up meant good care or not. I did not like that and the stresses in California are there.

I have friends that are in practice there and this kind of thing is a constant weight over their head. I didn't like that so—that is more prevalent, I think, in California than any other State in the country. So that was one reason, it was because I didn't want to be in the situation where I was practicing medicine as a guarding myself medicine but practicing a medicine that I could care for people.

I wanted to in the smaller community so that, rather than a big city, so that I knew the people, knew them personally so that I could not only take care of their physical ailments but know them as people which would help me better take care of them overall as a human being. So that meant a smaller community.

So with that in mind, I went to a number of smaller communities in California and the communities there are a small community for a reason. This town here is a small community because that's the way Iowa is really oriented because of the farming and it's different than the California.

The people in this town are very stimulated and constantly on the move and doing things and they are enjoyable to be around. It's a small town not because nobody wants to live there but because of the agricultural setup. So that made it different than California. And then I'd always—there's other things down the line. It was a chance to find out if I, an internist, would enjoy just doing what would be more

of a general practice. And it was an opportunity for me to try that out with little risk to myself.

At worst, if the three doctors recruited left, they would have a clinic building. That would always make it easier for them to get other doctors.

Senator CLARK. It was your understanding it was a 3-year program?

Dr. DOWNIE. Two-year program. But at the end of that time if I decided not to stay, they would always have the building which would make it much easier for them to get a physician.

They did not pay any salary so they wouldn't lose anything there. That's the way it was billed to me.

Soon after we got into it we found that, yes, we had to pay the money back. That was upsetting because that wasn't billed and yet—

Senator CLARK. To pay which money back, now?

Dr. DOWNIE. To pay the money back for my 2 years of salary. That was not the way it was. I was told in Atlanta that I never saw the piece of paper that mentioned that thing of reimbursal until I signed my contract. Up to this time it had all been told to me that my salary would be paid by the Government, as them supplying as part of a different part of a health initiative as one branch of trying to get more medicine to more people.

That's what my understanding of the program was rather than them trying to do that, that community having to pay back my salary.

Senator CLARK. Now, it is your understanding that your entire salary for both years have to be repaid?

Dr. DOWNIE. No, but what they call a fair amount. But I can't remember the legal terminology on the piece of paper, especially not all of it, but a fair amount of it. I think it's a figure of two-thirds or something like that which is upsetting to me because that's not what I understood and at the same time on a medicare patient, I can only accept them on consignment because I am a Public Health official.

That's saying I can't charge the normal going rate for all doctors so that I can—I'm being told that instead of a \$9 office charge I can only get \$5 because I am a Public Health official. Well, I'm not. I have got to pay my own salary back. I think the—

Senator CLARK. Don't you have a contract?

Dr. DOWNIE. The contract that we have that I have had and signed, I have a copy of it. It is very vague. It doesn't go into these things on the contract that I signed about this reimbursement. This reimbursement thing came out in a large book which is yea thick with a number of things in it.

Senator CLARK. Well, we would certainly like to go into that matter itself and look at the—do you have a contract Cecilia and terms of what you entered into with the Federal Government on this?

Ms. PODHAJSKY. Yes. We have a copy of it.

Senator CLARK. These things are not provided to you in the contract?

Ms. PODHAJSKY. We knew that we were to pay the reasonable cost which is like I said, it's split up into categories and we can deduct first salaries and this type of a thing then whatever is left then we have to pay back a percentage. This was our understanding. We understood this for the 2-year period but then we got this letter like

I said that it was changing. That was what upset me, that we entered into a contract thinking that this might be changed. But no, we understood because I think it was through conversation that Dr. Downie found out that we knew this but he did not know it when he signed his contract.

Dr. DOWNIE. Which I probably wouldn't have signed my contract if I had known it because the way I looked at it; therefore, the town is doing everything and I think that's not fair.

If the clinic makes money then I and Dr. Westhoff are making it work with the help of the supporting people. But therefore, we are making it work and that is great. But if it doesn't work for some reason, maybe the town cannot pay three doctors, then the town takes the whole burden. And the way I look at it that the worst they would have taken burdenwise was to keep the clinic building which would always provide them a good playing card for getting other physicians.

Senator CLARK. Well now, doctor, the National Health Service Corps as far as you were concerned was primarily a referral system.

Dr. DOWNIE. Certainly, yes.

Senator CLARK. Or almost absolutely that.

Dr. DOWNIE. And that is the way, to be very honest with you—I don't have a tape recording of everybody down there, but of this meeting that I went to in Atlanta—that was the way it was billed.

Senator CLARK. And what about the other doctors?

Dr. DOWNIE. Dr. Westhoff is, I think, in a little bit better position because he does have an obligation to Public Health Service.

Senator CLARK. Can you describe that part of the National Health Service Corps?

Dr. DOWNIE. Well, this is really a part of the Public Health Service and you can use it in any number of ways. You can work out in a hospital or in the National Health Service Corps but usually to have certain amounts of your medicine paid for, say undergraduate education in terms of medical school paid for by Government loans, that then you are able to pay those loans back by working 2 years for the Government.

I believe it is something like if you work 1 year for the Public Health Service, it is 65 percent of the loan is knocked off. If you work 2 years, it is 75 percent so you are only left the 15 percent and another year, I think, they knock off another 5 percent. I'm not sure of these figures but it is certainly a way for them to give money for medical education then with an obligation the physician has to take some Public Health Service job or in the Public Health Service depending on where they want him to be.

Senator CLARK. Does that program, as someone who has just come out of the medical program, make any sense to you?

Dr. DOWNIE. I have friends who could not have gone through medical school without it, without some kind of loan system like that. And I think it is good in one sense that it may take a number of these people and put them in the situation of rural health care that they might not have done. And for sure even if they don't like it, know that they don't like it rather than turning their back on it without trying it.

There are a number of guys that had gone into the program. There were two guys from North Carolina and Pennsylvania that had gone

into it with just this thing, they were paying on loans and both of them liked it so much that they were planning to stay in small towns that they otherwise would have never thought of going to.

And I think all I'm trying to say is if the Government is really concerned with national health care and getting them in the right spots, they better check into this thing or at least bill it very fairly at these meetings to doctors that are thinking of this program that the community is expected to pay back the loan. And I dare say that they would have a lot fewer doctors signing up.

And that is not an objection to the town because I am glad I did because of that, but I'm very angry about the misrepresentation there.

Senator CLARK. I think your point is very well taken and I can assure you that we will follow up on it and find out who instructed you on that and talk with the people in Atlanta and see why they are telling people that. Apparently they told the people you had contact with, but not you.

Dr. DOWNIE. Right, right. But this actually was a confidence that would have been carried by the National Health Service from Washington. It was just held down, not actually in Atlanta but near Atlanta. It was at a retreat place.

Senator CLARK. But near Atlanta?

Ms. PODHAJSKY. The people we dealt with were in Kansas City so, I mean, it wasn't the same people telling the doctor at that conference and the same people telling us something differently because we weren't dealing through the same region.

Senator CLARK. Tell me now how long that the two of you that followed those records—how long do you think it will take—I know this is only a guess—to make that clinic self-sufficient?

Dr. DOWNIE. Well, are you asking me the question?

Senator CLARK. Either of you or both of you. Whoever is in a position to judge.

Dr. DOWNIE. We are, obviously as any new thing, we are in the hole for the last couple of months. Part of that is a part of the medical building and the fact that we know what we are expecting we will probably get a lot less. We have probably been undercharging people for the amount of care they have been getting from the amount of time spent in the clinic. And the other things are really related to just getting the facility going.

You have all the equipment and you forget about the supplies and stuff and we are in the hole now. And I guess we have been estimated that up to 6 months before things—before we are treading the right way which really isn't, you know, reasonable.

Senator CLARK. No.

Dr. DOWNIE. Some friends that I have that go in practice say that maybe in 6 months they will be showing some bonus, some earnings.

Senator CLARK. After a year the clinic and your salaries, in other words, everything, will be self-sufficient.

What is your guess, Cecilia?

Ms. PODHAJSKY. We consider carrying the margin that we are carrying on the building.

Senator CLARK. I mean considering everything.

Ms. PODHAJSKY. Considering everything I really think if we are really showing self-sufficiency by the end of 2 years that will really

be doing good because like Dr. Downie said, there is all these things that initially when you are sitting down with figures you don't really think about what the total cost of all these little supplies, the things that are used, expendable supplies daily, what they add up to. And just—no; we were prepared.

You are prepared but yet you hate to see it on paper. For the first 6 months we will finally show a loss and after 6 months we won't show a profit but the loss will decrease and we start picking up. So by the end of the first year we, you know, I don't think that we'll even be breaking even.

Senator CLARK. Take a couple of years?

Ms. PODHAJSKY. Right. At least.

Senator CLARK. Now, is that about what you thought it would take or does that surprise you or—

Ms. PODHAJSKY. No; it really doesn't surprise me. It was hard—we really didn't have that much time thinking about it. We knew that it was going to take quite a quantity of money building a three-man clinic in itself and we were able to get a mortgage through our local banks. And so that in itself and we also have received a little bit of care or aid, I should say, through the rural health initiative's grant which is under the Tama County Health Providers in the title of the grant which covers all of Tama County. And so Traer received some aid through that which is another story in itself. I shouldn't go into that.

I'm not for grants after this but we had, I mean, you know that it is going to cost a lot of money to set it up and especially like I said, you have to generate in order to provide three physicians with a salary and all the equipment. You have to generate a lot of patients and it takes time. It takes a lot of time.

Senator CLARK. Is the rural health care person here? I met him earlier. Maybe we will ask you later about that.

I must say that I for one am not prepared to appropriate an awful lot of Federal loan for National Health Service Corps or rural health providers, their extenders, or anything else. That these programs are not working.

They are not bringing doctors to rural areas and they are not bringing health care to rural areas that they didn't otherwise have. I'm not—

That is what this hearing is all about to find out whether in fact these programs are working or whether they aren't working. And if they aren't, we don't want to fund them.

Dr. DOWNIE. I think we would estimate that the program is working.

Ms. PODHAJSKY. The program is good and working. It's just the bureaucracy end of it.

Dr. DOWNIE. It is working because a lot of these—when I was back that was what really got me excited. A lot of these graduates had no thought whatsoever of a small town. But they had their 2 years to get rid of their loan but they ended up liking the small towns so well that they stayed there. And there were a lot of guys there that that is working for.

I think if somebody advised me right—asked me, "Well, what do you think about it?" I'd say no to them and I'd say no because of what has come up about the misleading. Or at least I'd tell them that. I'd

tell them what it was and let them make that decision, but I'd make darn sure they understood these things.

And I asked the question, "You mean the town pays none of the salary back?" And the answer was "Yes." You know, so that was my understanding of the persons I talked to so I think it works.

Senator CLARK. Let's go at it from this—

Dr. DOWNIE. I think that needs to be taken out—it needs to be more clearly defined.

Senator CLARK. In other words, the person down in the Atlanta area who instructed you on that point was wrong?

Dr. DOWNIE. That's correct.

Senator CLARK. Let's look at it from this point of view. What about the benefits or lack of benefits or the wisdom or unwisdom of having done this. In other words, the health care in the community not so much your attitude in this respect, whether you were misled and so forth which, I think, is very significant. But what about Traer or what about Tama County? Are they better off or worse off? Would you have been better off not to do this, Cecilia, or can you talk a little about that.

Ms. PODHAJSKY. Oh, no. No, I—well, like I said, to me it is much harder for a small community. They are not financially really able to spend years searching for a physician and trying to find one who is suited for their community. And through the National Health Service Corps that doesn't necessarily mean just because the physician comes that he is going to like it, but he has 2 years to get to know the people. And this is the whole spot of the program is that the matching up of physicians, that they have a chance to see the community and meet the people before they are committed to the Corps, the fact that they get some idea of what the community is like and that there are more chances that they will like the community after they have practiced there and will stay. And this is what all the communities are hopeful for is the fact that we built the clinic but we, by no means, want to maintain the clinic forever.

It is hopeful that we can show self-sufficiency and after a couple of years or so that the physicians will purchase the facility.

Senator CLARK. In other words, this would be kind of a stimulus to get some doctors in here, to build the clinic, and then you would hope that it would go on its own for the rest of—

Ms. PODHAJSKY. Right; this is the whole end of the program—is the fact that the physicians come to the community after seeing it and they pick that community; hopefully, they will like it and stay there and that they, in turn, will—you don't build a clinic for a community to maintain. I mean, the clinic is built to entice the physicians to come and help them set up a good practice with a modern facility and everything that they need. And then they will eventually purchase the clinic from the community. Because it was at no time any of our thoughts that we constantly, you know, just bring in physicians on salary.

We tell the physicians that this is to be their practice and that they will want to assume the responsibility of the practice.

Senator CLARK. So you feel that although you have had an awful lot of bureaucratic problems in terms of getting the forms here on

time and in terms of particularly the view that you had that the salaries would be reimbursed except for——

Ms. PODHAJSKY. On a percentage basis.

Senator CLARK. On a percentage basis for 2 years, that now it is going to be 1½ years rather than 2 years.

Ms. PODHAJSKY. Right.

Senator CLARK. But in spite of those two problems, you don't feel that you made a mistake. You think you are happy?

Ms. PODHAJSKY. No; I don't think we have——

Senator CLARK. You are happy that we——

Ms. PODHAJSKY. Right; we have got two fine physicians and they are specialists. They are not only good doctors, they are good internists. And I think we have got really good medical care to Traer and the surrounding areas.

Senator CLARK. Now, Dick, I think you don't—you're not so sure you share that view. Do you want to expand on that?

Mr. DAHMS. You know, as I looked at that map it looks like there are probably 25 counties.

Senator CLARK. Twenty-five, I believe.

Mr. DAHMS. There is not too much in southern Iowa evidently. I wonder what is the difference between the doctors, the teachers, and the engineers profession. Do medical schools have placement bureaus? For instance, University of Iowa?

Senator CLARK. Surely, I'm not the best authority on that. I'm out here to listen and learn but I'm not sure I know the answer on all of the questions. But, yes, I'm sure they do have.

Mr. DAHMS. I can see where they went to Atlanta to, you know, to show these prospective doctors what is open, but I still can't see why you have got—why 25 doctors, if we are graduating 200, 25 wouldn't be interested in going into those 25 counties, funded somehow, helped somehow.

Senator CLARK. Let me tell you what the doctors are——

Dr. DOWNIE. They aren't producing 25 general physicians.

Mr. DAHMS. Then maybe the State's program is wrong.

Dr. DOWNIE. Well, how are you going to determine when people start medical school. I mean, I didn't know what I wanted to go into. I mean, you know you want to go into medicine. Whether I go to pediatrics, obstetrics, I mean, really you have to have a pretty good sized town population. And I think that is the problem.

They can't decide when somebody enters medical school that they are going to force 25 people into wanting to become general practitioners. There are now programs being started at many medical schools through the country to direct people into that kind of practice which would be a more general medicine practice. But still at the same point, there has got to be an individual choice of those people whether they want to do that or not.

Mr. DAHMS. What percentage of your workload does require specialist care?

Dr. DOWNIE. Oh, not much except that the feeling of young doctors of inadequacy by trying to do too much and not doing it well versus doing something that you are very familiar with it and doing it well.

It is the same in any profession. You prefer doing things that you are comfortable with. The more you specialize, the easier it is to be comfortable but you tunnel your vision.

Mr. DAHMS. Could there be a way that if you are a good doctor and there were something that you couldn't handle that you could refer them to Iowa City, Waterloo, Cedar Rapids?

Dr. DOWNIE. And that is available. And it really amounts that if you are trained in certain skills in medical school and residency programs it's—you may not want to give up those skills that you know how to do to somebody else just because of your locality; say that you are just in a smaller town and you don't have the hospital facilities available to you right there or the equipment to do what you have been trained to do.

You may not want to give it up so you automatically say, "I cannot practice the kind of medicine that I have been trained to do in a smaller community." In other words, the university hospital setting, no matter what you are thinking of taking, you are still put in the situation that you are learning the hottest stuff that has come out and you are getting trained in that stuff and most of that stuff is not at a community of even 100,000. So that you have to be willing to want to give all of that up and practice a really different kind of medicine than you are being taught in medical school where you are being taught a lot of specific, full, high-powered medicine.

Senator CLARK. Do you think that is what you ought to be taught? I mean, are you critical of that approach?

Dr. DOWNIE. Oh, boy. Well, yes and no. And this is where I think Dick does have a point. Yes; I think we need the specific development and whatnot.

I think medicine, unfortunately, has gotten lost in that specific medicine. Physicians are able to do all of these procedures the number of them that I can do, but most of them aren't trained in taking care of people. They are becoming more and more trained in taking care of bodies. And that sounds bad, but there is very little—even in my own program, the training is to make the best decision based on the facts. OK, and that is important but that is misleading and that is where medicine has gone. Medicine has misled one to think that it is a science, and doctors say it isn't a pure science. They may try to make it a pure science but it is an art. It can't be a pure science.

It needs to be based where you are dealing on factual information and doing the best for your patient. But it is combining that intangible for good patient care and caring for people that is really lost. And I think that is why it is becoming the tendency to make it look as if it is a science so that the doctors that are in it say, "Well, it is science and I have got to stay up on what is the hottest and stay in a position where I can do those things."

Senator CLARK. Let me ask you this. This is only the fourth day of hearings and it is a little dangerous to speculate on exactly what everyone thinks after hearing 4 days of physicians and other people, townspeople, and so forth talking about this problem. But in a nutshell this is what we are hearing from the physicians as to why they are not prepared to go out into the smaller communities as a community of 1,000 or 500 or 1,500.

First of all, the major complaint we get is that they don't want to go into solo practice. They don't want to go out alone. I'll just throw this all out.

One, that they don't want to be out in solo practice as it was with doctors in communities of 30, 40, or 50 years ago because they feel they

have to have somebody else to consult with. They don't want the professional isolation. They don't want to go to a community where there is no hospital because they have immediate what you would call more specific or more up-to-date facilities. They would prefer to go where there is a hospital.

Secondly, that physicians can make a good living any place and that, therefore, it isn't required to go out in a small community and work 24 hours a day or 7 days a week or without vacation with nobody to cover your patients and so forth.

It is a lot easier to go to a community where you have got a group practice. You can take off for a few days or go to a medical convention or whatever and have somebody covering your patients.

And also, many doctors and their wives would prefer to live in a larger community apparently for social or cultural reasons and so forth as well.

For all those reasons there is a national tendency even for those young people who come out of the small communities and go to medical school not to go back there but rather to settle in a larger community.

Does all that fit your view of it?

Dr. DOWNIE. Oh, you betcha. One of the crucial decisions for my coming here is whether Dr. Westhoff was coming and Norm. I made it clear to them if we could have a third physician at the same time really, but it was definitely in my mind that I would not come to a community with just two doctors because there are my own things that I want.

You know, I have my own life that I want to live. And if I don't have that time, I won't be a good doctor either. I will be a very tired and won't make good decisions and I won't practice good medicine. These studies have been documented that physicians who have more call areas make many mistakes and make more bad decisions. There are plenty of studies to document that.

If you don't have the time to think about things and time off to read and whatnot, you cannot do it. So that is important. That is what we have here.

Every third night on call is really no big deal. I mean, we really get called a couple times a night, occasionally more.

Senator CLARK. Well, how many hours a night do you work?

Dr. DOWNIE. Well, I averaged in the office usually about 8 to 6. And if I made hospital calls, it usually starts around 7, 7:30. So what is that?

Senator CLARK. So roughly from—

Dr. DOWNIE. Ten hours a day and then probably at least 2 or 3 hours depending again if you have to admit somebody to the hospital and they are fairly ill. It might be longer than that. It is an average of 10 hours a day.

It is not just seeing the patient; it's taking the time to sit down and write up their charts and thinking about their cases and be organized. It does take time.

The other point you made about the fact that—the money thing, that doctors are needed anywhere. Yes, that is true but the money can be made easier in a big city, if you will, because you can get into big groups. You can get into a group where you are on call the 11th night. So it is easier to get a better call schedule there and yet make the same type of money there.

You can subspecialize so that you have narrowed yourself, too. You don't have to do a number of other things that you don't have to do, things that you are not familiar with.

And so I agree with those points. I think that is what this community has meant. We have three physicians. We are really working to make people used to the fact that there are three physicians and that when I'm not on call, they call the clinic and they get the doctor that is on call. And that is the same thing Dr. Westhoff is doing and we are trying to create that so that people get dependent on all three doctors and that will make the call schedule work out better and will eliminate that one image that doctors have of having no family life or time for themselves.

And that would probably be the biggest objection of a guy going into a small community that he would not have much of his life or time to himself.

Senator CLARK. I wish we had more time. Unfortunately, we are already over the hour and we have set aside 2 hours. But we are very grateful to all of you for coming and giving your opinions. Thank you very much.

Ms. PODHAJSKY. I want to interject that if you want not only young doctors, Dr. Lencolm approached us to the fact that he would like to join another three-man clinic.

Senator CLARK. And his move Dysart over here was based on the establishment of that?

Ms. PODHAJSKY. Right. He would not have come over on the fact that only one came. He said that as one physician alone he couldn't cope the load any longer by himself. And so it is not just the young physicians that say they don't want to work alone.

I don't think any physician really wants to be dependent in an area all by himself 24 hours a day, 7 days a week.

Senator CLARK. Thank you very much.

The next panel is Dennis Mallory, Dr. Mallory, a National Health Service Corps physician at Toledo; and Pam Wood who has been very active in Toledo health affairs; and Eugene Anderson, a Toledo businessman.

Let's go right ahead. I think we are going to hear first from Dr. Mallory and then from Pam Wood and Eugene Anderson. And just each of you go ahead and proceed for 5, 6, 7 minutes on anything that you think relative to our discussion here. And then we will have questions.

**STATEMENT OF DENNIS I. MALLORY, D.O., MEDICAL DIRECTOR,
TAMA COUNTY MEDICAL CENTER, TOLEDO, IOWA**

Dr. MALLORY. All right. I would like to begin by saying—well, I'd like to identify myself. I am a doctor, Dennis Mallory. I am a National Health Service Corps physician. I have been in the National Health Service Corps now for almost a year and a half, since July 1975. My time is up July 1977.

Basically, I have one beef and I can summarize that. We can work on that later. But my beef is that, as a practicing physician by myself, I have had difficulty with the local board. And why I have had difficulty with the local board, I think, is because of the local board's over-

zealousness, their inability to deal with medical matters. And I think this is basically why we have had trouble.

We have offered good medical care to the community. I don't think the community is aware of the difficulties between myself and the board.

Aside from that, I'm very happy where I'm at and I am planning on staying in the community.

Senator CLARK. Well, good. Can you tell us a little about how you got into it and why and where and under a scholarship program or—

Dr. MALLORY. No; it wasn't. No; I did not have a scholarship and I did not need to pay back any money because of loans. I came to Tama-Toledo area because I felt that it was a good area to practice medicine as a general practitioner.

I have had my practice in Dallas for approximately a year and had difficulty because of too many physicians, the high prices of medical care of that area and I felt that I wanted to go in by myself or at least try it by myself.

And I came to Tama-Toledo because it was an area that needed health care. I am happy in the Tama-Toledo area.

I have more than enough work to do and I'm planning on staying here as of July 1977 on my own.

Senator CLARK. I don't want to ask you a lot of questions now because I'd like to go through, but just general by way of—in other words, you got into the National Health Service Corps much in the same way as Dr. Downie, more or less as a referral agency for you rather than owing any obligation; is that an accurate statement?

Dr. MALLORY. No; I owed no obligation. I came to the Tama-Toledo area to establish a practice on my own. And I felt that the Marshalltown Area Community Hospital had the necessary referral people so that by practicing medicine in Tama-Toledo that I could refer anybody that I wanted to the Marshalltown area.

Senator CLARK. Now, what is your connection with the National Health Service Corps?

Dr. MALLORY. I am under contract with the National Health Service Corps for a 2-year period.

Senator CLARK. Now, what does that contract roughly mean? That you will stay 2 years in return for what?

Dr. MALLORY. I am paid a salary per month.

Senator CLARK. I see. So it is a guaranteed salary in return for 2 years of service. That is about all that I—

Dr. MALLORY. That's correct.

Senator CLARK. Then they acted as a kind of referral agency. That is how you came in contact with Toledo-Tama was through the National Health Service Corps.

Dr. MALLORY. Well, the National Health Service Corps presented five or six different, well, I can say sheets to me on certain areas. I received one sheet on the Toledo-Tama area and this was the sheet that I received. And out of five or six that I received, I picked this one because of the economic condition in this area.

Senator CLARK. Yes.

Dr. MALLORY. In other words, not to my advantage during the 2-year contract but after that contract.

Senator CLARK. Yes. So you saw it as a way of getting permanently settled, not simply as a way of coming out—

Dr. MALLORY. That is correct.

Senator CLARK [continuing]. For a couple of years.

Now, just out of curiosity, were you here for the other panel?

Dr. MALLORY. Part of it.

Senator CLARK. Dr. Downie, in particular, felt that there had been some misrepresentation about payment, whether the community would have to pay for a part of his salary. He was under the impression the community would not have to make up the difference of the salary for the first 2 years. Did you have the same problem or not? Were there any misrepresentations made to you, I guess, that you can recall, in terms of your arrangement with—

Dr. MALLORY. National Health Service Corps?

Senator CLARK. National Health Service Corps.

Dr. MALLORY. Not so far as I know. The National Health Service Corps promised me a salary for a period and they have kept that part of the bargain. The only misrepresentation has been through the local board and that, I think, has been more a misunderstanding more than anything else.

Senator CLARK. OK. We are, of course, in this area to try to find ways to encourage physicians to come to small communities. We are trying to understand what gets them there and why they are not going there.

What can you add by way of assisting to get them there? Do you think that is an effective way to get physicians in small communities or what is your judgment of it?

Dr. MALLORY. I think it is an effective way to get physicians to a community, but I think you are going to have to give more decision-making power to the physician.

Senator CLARK. In what sense?

Dr. MALLORY. Well, you can't tell a physician that he can charge so much to see a certain patient when the people who are telling him that know nothing about the practice of medicine.

Similarly, you cannot have a member on the board who is a member of the medical profession who is in direct competition with the NHSC physician. We have a circumstance where one of our local physicians, well, no longer on my board but on one of the other boards. And I think that is good for his input, but I also think that he cannot go totally unbiased in his advice.

Senator CLARK. Well, how does that relate to the National Health Service Corps? Do all National Health Service Corps establish a local board? Is that the idea?

I'm trying to think what the connection here is of the board with the National Health Service Corps.

Dr. MALLORY. Well, I think most of them do. The National Health Service Corps turns over the control to a local community board. That local community board has most of the control over that physician, and that's my biggest beef. I think the physicians could have more say—

Senator CLARK. I see.

Dr. MALLORY [continuing]. In what his duties are going to be.

Senator CLARK. Well, you will have after 2 years; won't you?

Dr. MALLORY. Well, yes, if I stay which I'm planning on staying.

Senator CLARK. OK. Let's hear from Pam Wood. You sound like you have a cold.

STATEMENT OF PAMELA WOOD, TAMA COUNTY MEDICAL CENTER,
TOLEDO, IOWA

Ms. WOOD. I was going to say, "Is there a doctor in the house?"

We were asked to come speak for 3 minutes so I wrote mine down. I can only talk for 3 minutes.

I feel that the National Health Service Corps program is a very valid and a helpful one to both small and large underserved areas. Primarily, it enables lay persons from the community the advantage of establishing a medical practice with the expertise of Health, Education, and Welfare personnel.

The financial outlay from the community is, I feel, greater than originally thought in the majority of the cases. And because of this I see some flaws as far as the reimbursement schedules are concerned.

Senator CLARK. Same problem that—

Ms. WOOD. Same problem that we saw earlier.

Senator CLARK. You were under the same impression that—

Ms. WOOD. We would pay back a percentage of the physician's salary when the clinic became more self-sufficient, after all the other debts to the community were paid.

Senator CLARK. And how has it worked out? Don't you pay a percentage?

Ms. WOOD. Not at this point, but we were given—you know, after the five quarters, yes, you will pay right now. And we have been in the process for five quarters so subsequently—

Senator CLARK. You have not paid anything in the first five quarters?

Ms. WOOD. Right.

Senator CLARK. But you think you will be in these quarters. You were under the impression that it would be a 2-year period?

Ms. WOOD. Not necessarily. But when we became self-sufficient enough to carry that.

Senator CLARK. I see. And you're not, you feel?

Ms. WOOD. Yes, we still owe the bank a lot of money.

Senator CLARK. And yet you are being required to pay?

Ms. WOOD. After having worked with the program for almost 2 years, the one major area of concern on my part is communication time lapses between regional offices, Maryland, and local board representatives.

This poses tremendous potential for misinformation between all parties. Plus, the community representative is responsible to a great many people and it is difficult to keep them informed of developments that take place over many phone calls and different opinions on even one specific issue.

After almost 7 years of physician recruitment in the area though, I feel that definitely the National Health Service Corps program is the most effective means of obtaining additional doctors for rural America.

I was happy to read that President Ford had signed the bill to continue the scholarship program.

Senator CLARK. Yes, that is the health manpower program that I was just referring to. And I must just repeat what I said earlier that within about a month you ought to talk with HEW because he did just—in the recent bill that you mentioned we had an amendment

which allowed HEW to waive requirements that communities contribute to the cost of paying salaries to health care for Corps personnel. So that may affect—

Ms. WOOD. So that will probably cover that.

Senator CLARK. That may well affect that. I'm sure that that waiver is not automatic, but at least it is available if that is the case.

Well, let's go on to Eugene Anderson and then I'll have some questions.

**STATEMENT OF EUGENE A. ANDERSON, SECRETARY-TREASURER,
TOLEDO EMERGENCY SERVICES, TOLEDO, IOWA**

Mr. ANDERSON. Senator, I just compiled a little bit of information I thought might be interesting to you. Not only as a businessman, but also I am secretary-treasurer for the Toledo Emergency Service.

Senator CLARK. Good.

Mr. ANDERSON. I have been in each doctor's office several times. I know each doctor personally and I don't think there has been a reduction of workload anywhere among any of the doctors even with the addition of our third doctor.

The number of emergency calls since the beginning of our service in 1972, January 1, 1972. In 1972 we had 90 calls; 1973, 86; and 1974, I couldn't find the record; 1975, 89; and as of 9 o'clock this morning, 142. This deals strictly with emergency calls.

Thirty-two of these calls this year were terminated in doctors' offices. The balance usually end up in the hospital. We had extremely good communication with all three doctors.

I think our situation is very comparable to a lot of other communities. We are located 23 miles, approximately 23 miles, from Marshalltown Area Community Hospital east which is where we take most of the patients.

Senator CLARK. How long does it take you to get them there?

Mr. ANDERSON. Depending on traffic situations, anywhere from 15 to 20 minutes. And again, the traffic situations are your biggest problem. This, I think, is a major factor in getting new doctors in your location. Because if you have a good hospital—Marshalltown, I don't know what they have for numbers right now of doctors, but I know they have quite a few. And it is easier for a doctor to set up right in Marshalltown. But I'm glad to say they aren't all in Marshalltown.

The Toledo Emergency Services have a total of 32 active emergency members at this time and 29 are certified EMTA. I don't know, this kind of supplements the doctors somewhat to help get the patient prepared for the doctor and look at them if it's a situation where you have to ride into the hospital. And we can move them right into the hospital.

I have a kind of a personal insight on a young doctor. His family is my neighbor. He is the orthopedic surgeon. He just graduated this last summer. He was offered between \$80,000 to \$100,000 a year to start out in California. He ended up taking a position on the staff at the Iowa University Hospitals as a professor. He instructs. He looks very seriously at California with that \$80,000 to \$100,000 salary income and I think this malpractice insurance has come into play in a lot of these young doctors. I think this is what decided his move.

I don't know what we can do as far as—it is coming to Iowa just as sure as it is right in California right now. And I think this is something that the Government could look into a little bit more and see what could be done to take care of this problem.

I don't think national health care is the answer. I really don't. I think you look at your post offices and things right down the road and if it goes that route, I'm sure not in favor of it.

That is about all I have to say.

Senator CLARK. All right. Fine.

Let's have a few questions now. First of all, Dr. Mallory, you were not from Iowa I gathered. You lived in Dallas, did you say, before you moved here?

Dr. MALLORY. Well, I trained, I went to medical school in Iowa and I am originally from Iowa.

Senator CLARK. At Des Moines?

Dr. MALLORY. Yes.

Senator CLARK. And I'm just wondering whether there are any particular difficulties in coming into a community under that program. You had immediate acceptance or reasonably? Does it take a while to establish a practice?

Dr. MALLORY. Oh, I think it takes a while, yes. Presently we have the two other local physicians in our community, Dr. Maplethorpe and Dr. Havlik here today.

Senator CLARK. Yes.

Dr. MALLORY. And both of them have established practices. There is a large enough patient load that, I think, after a period of time that we have, you know, kind of separated that out amongst ourselves for the coverage. We have traded amongst ourselves.

Senator CLARK. Yes.

Dr. MALLORY. I feel that in July of 1977 that I can make it on my own.

Senator CLARK. And you are planning to stay. And what are the factors in deciding whether or not to stay in a small community. Lots of communities, small communities, have attracted doctors and they stay 1 year or 2 or 3 and then they leave. What factors would affect your decision?

Dr. MALLORY. Well, frankly because I feel that I have built a big enough practice so far and that I'm young and that I have my future ahead of me. And I'd like to build my future in that community.

Senator CLARK. Uh-huh. You like the community, generally.

Dr. MALLORY. Yes. I ran for school board just recently. I lost, but I'm going to try again.

Senator CLARK. Good, good.

Now, Mr. Anderson, what is your general—we are principally concerned here, of course, about the health care in rural communities. Do you think, generally, that the people of this area, of Tama County let's say, that are served by these two areas, Toledo, Tama and Traer; do you think people are getting good health care service here?

Mr. ANDERSON. I think they are getting good health care service. I think we have got to look way down the road in the future in adding more doctors because I don't know about Dr. Havlik and Dr. Maplethorpe. I'm sure they are thinking about some day retiring and if they are then—

Senator CLARK. But now you have had adequate care.

Mr. ANDERSON. We have adequate care. I don't think I am qualified to say so, Senator.

Senator CLARK. Yes; but just from a layman's point of view you have that impression.

And do you think you would have had without the National Health Service Corps? Do you think that has made a significant difference or do you think you would have attracted anyway? What is your feeling about that?

Mr. ANDERSON. Well, going back several years ago, I was on the same board that—or not necessarily board, but organization that Pam is on. And we spent several years trying to get a doctor, sending letters, making contacts with various medical schools with no response.

Senator CLARK. You never had any success at all in all these years?

Mr. ANDERSON. No. I think we might have had one or two doctors look at our community but that was about it. Then with the National Health Service Corps, through this referral type thing where they can come and visit the community and look it over instead of getting into a community bid basis where you have got to promise a doctor half of the town to get the doctor in town. This gives him a chance to look at it and see what the community is, what it has to offer; and if they are interested in it, at least to have a chance to say so.

Senator CLARK. Well, now, Pam, what did you do down in Toledo? Did you build a clinic there?

Ms. WOOD. Yes. We remodeled a building into a clinic.

Senator CLARK. How much did that cost, do you remember?

Ms. WOOD. Oh, to remodel the building it probably cost us—probably close to \$20,000.

Senator CLARK. And did you borrow the money?

Ms. WOOD. Well, some of it was donations.

Senator CLARK. And the rest you borrowed?

Ms. WOOD. And the rest we borrowed from the bank.

Senator CLARK. And one we passed was a provision for low-interest, long-term loans.

Ms. WOOD. I think that would be a great advantage.

Senator CLARK. Is that something you might have taken advantage of?

Ms. WOOD. Absolutely.

Senator CLARK. What is your own feeling in terms of the health care? You have been interested in the area, obviously, for a long time. Do you feel that this area now, the number of doctors that they have, is adequately served?

Ms. WOOD. Well, certainly improved.

Senator CLARK. Greatly improved.

Ms. WOOD. Right. We have three additional physicians in the county that we didn't have previously. And you know, health expansion, we still think there is room for it though. You know, the extended care—

Senator CLARK. Right.

Ms. WOOD. Into any rural community. I don't think we can just pinpoint Tama, Toledo and Traer or Gladbrook or Dysart. There are other people living in other parts of the area that I feel get lost in the shuffle of larger cities. I haven't lived in Tama County for that long but I feel that there are other small communities that kind of lost out somewhere along the way.

Senator CLARK. What about this program? Do you think we ought to continue it? I am talking about the National Health Service Corps.

Ms. WOOD. I think it is a good program.

Senator CLARK. Why so?

Ms. WOOD. Because I believe like Dr. Downie and Dr. Westhoff and Dr. Mallory that it enables a physician to get started somewhere and maybe they, you know, wanted to go out to small communities but didn't have the financial help. They will stay.

Senator CLARK. Were you ever involved in efforts to get doctors?

Ms. WOOD. Yes.

Senator CLARK. In Toledo or this area?

Ms. WOOD. Right, in Toledo.

Senator CLARK. How long did you try or what did you try to do? Why do you think you weren't successful?

Ms. WOOD. A lot of the success, I think, depends on that you can't infiltrate a lot of the medical schools. You go to Iowa City and you don't infiltrate where you need to infiltrate.

Senator CLARK. What does that mean?

Ms. WOOD. Well, it means that you cannot get even to see the physicians that are coming out of practice as far as interviewing. You know, it is very difficult. Even in family practice clinics it is difficult to infiltrate to have interviews with the physicians that are coming out of practice.

Senator CLARK. Why do you think they are not prepared to come to a community of this size? What is the reluctance? Where did you have such trouble?

Ms. WOOD. I would say basically a lot of it is no hospital in the county. That was the main thrust of all of the physicians that came through. "We would love to come to your community, but no hospital is a large factor."

Senator CLARK. Why did you—yes, doctor?

Dr. MALLORY. I would say that the younger physician coming out today is trained to rely heavily on his referral services and the farther away his referral services are, a young physician today is not trained to be independent. And it is a very frightening thing to come out into practice and realize that you have a business enterprise and all the weight of all these patients on your shoulders. Before, you followed people around and had someone nod to you and say, "Oh, yes, you're doing the right thing." And there are very few young physicians who want to go out into a smaller community and take the entire responsibility on their shoulders.

Myself, I wanted to try that. I felt that there is only one way to go about it and that is to get my feet wet. So that's why I am here. And I may get hurt by it but I'm going to try it. But I don't think many young physicians are willing to do that.

Senator CLARK. Now, according to the statistics that I was stating at the outset—I wanted to stay with you for a minute, Dr. Mallory. We have seen that although the size of the medical school classes doubled in the last 15 years or so that the number of people who settle in small communities is continuously declining right on through the present time according to the statistics that we have. Why is that? Why, if we graduate more and more doctors and now we are beginning to graduate more and more general practitioners, why do those people prefer—even the ones who stay in the State, I mean,

why do they prefer—you mentioned hospitals. Can you give us any other—in your discussion with other people in medical school and so forth when they came out and before they came out—

Dr. MALLORY. Well, hospitals were one reason that you have—when you come out of medical training whether it be you just graduated from medical school or you have come out of an internship in the case of Iowa, you must have at least an internship to get a license to practice medicine. Of if you go ahead and get a residency and you become certified in that residency, then you go out into private practice you still, in a small community, do not have the big brother, or the mentor, or the teacher to lean back on to say: “Well now, look. I’m not too sure whether I can give that person that antibiotic or this antibiotic.”

Senator CLARK. So it is solo practice as compared to group practice.

Dr. MALLORY. Well, not even group practice. I think more of the younger physicians are gravitating toward, you know, a group practice where they have specialty areas to go to where they can ask for help. In the small rural area you don’t have that.

For example, my practice now. After say a year and a half of experience I find out that the more I learn, the more I don’t know and the more I depend upon my referral people or the specialists in Marshall County in the Marshalltown Area Community Hospital. I am very dependent upon them to go to them to say: “I don’t know what’s happening.” I have to refer the patient to them. This takes a certain amount of courage on the part of the young practitioner.

I am able to say that now because I have been out and I have worked with it. The young doctor when he goes into a new practice, if he feels like he can’t ask anyone a question, he is not going to go into that area. Now that is just one facet.

Another facet is the business aspect of medicine. Now, I still do not know exactly what is happening with title 19, for example, or Public Health Service.

Now, we have an Indian settlement in Tama County. We have many patients because of a government facility that I am required to administer medical care to and I automatically have to accept Public Health Service funds. Now, I’m not too sure exactly what the rules and regulations are concerning that and I have been there a year and a half. And I am very ignorant on taxes but we do not teach business in our medical schools. And the private practitioner going out into a small community nowadays doesn’t have the ability to set prices. He cannot set a price of \$10 for an office call and expect title 19 or medicare or medicaid to pay him for that. If he accepts assignment, then he only can receive 80 percent of the price that he sets. And if he sets a specific price, say \$10, then he is going to be reviewed by a government agency either State or Federal.

Now, I didn’t know anything about that before I came into practice. When you have a new physician graduating, he is going to steer away from that. He is going to say, “Hey, I don’t want anything to do with that. I don’t know anything about it. I’m going to get stung. The least I want to do is provide an income for my family. I’m not trying to get rich. I don’t want to drive a Mercedes and have a swimming pool, but at least I want to provide an income and that is getting harder and harder to do.”

Senator CLARK. So you would tend to go to a group where you wouldn't have all the business problems.

Dr. MALLORY. I think that most physicians who have graduated from the schools now, from what they get out of their training, they are gravitating towards a group practice where the group has an accountant and so-called sponging or absorbing factor of large facilities and the people who know how to do that.

The general practitioner that goes into a small community, he assumes all that on his shoulders and I am a baby when it comes to business. I know nothing about business and I'm finding that out.

Senator CLARK. Now, I want to come to Pam Wood and others of you pitch in too. Cecilia, I think, earlier mentioned the National Rural Health Initiative which is a Federal program. Can you tell us what that is about? Have you worked with that program, Pam?

Ms. WOOD. Yes.

Senator CLARK. Can you tell us what it is?

Ms. WOOD. It is a Rural Health Initiative grant which—primarily when we went into that, there was Cecilia, Rex and a couple of us from the southern part of the county and Dr. Charles and some other people. And initially we went into the grant with a thrust of mental health and then some equipment-type things to help with the Corps sites already established. However, it did kind of expand and then we found out also with that Rural Health Initiative grant which we got which was \$400,000 for a 3-year program. That also has been a self-sufficiency program within that 3 years.

Senator CLARK. You mean after the 3 years?

Ms. WOOD. Right. We already have obtained the services of a clinical psychologist who will work in the county which is a great thrust, I think, as far as mental health goes. He will work so many days in the northern part of the county, so many days in the southern part of the county, also in the two outlying areas.

Here again, you have a problem. We are talking about reimbursements. The psychologist, you realize, if he is not under the direct supervision—that doesn't have to be the direct supervision of a physician, however, he cannot get reimbursements from Blue Cross and Blue Shield, medicare, medicaid, and these kinds of things if they don't come under the physician's type program.

Senator CLARK. I'm not sure what that means.

Ms. WOOD. Well, that means if a physician does the referral to a psychologist then the physician should bill the patient for the psychologist's service and then can be a reimbursable type thing this way.

Senator CLARK. And how would it work better this way?

Ms. WOOD. That the psychologist works like the physician's assistant or the nurse extender, could receive full payments for their services provided. What they need is a health provider number.

Senator CLARK. A health provider number? What is that?

Dr. MALLORY. Each physician has to have a health provider number in order to be paid by Blue Cross and Blue Shield.

Senator CLARK. In other words, he has to be available for reimbursements.

Well, now, to come back to the Rural Health Initiative, is it of any value and if so, why and if not, then what is your recommendation on it?

Ms. WOOD. We are just getting started in it and there are a lot of pros and cons on it.

Senator CLARK. How is that nationalized medicine? Just assume I know nothing and you tell me what are the pros and cons?

Ms. WOOD. There again, that the board without the input—

Senator CLARK. What's the board?

Ms. WOOD. The board of providers, OK, and mostly lay people. We do have a representative, however, from the county health services on the board. We have a representative of the Tama County Medical Society on the board. We have advisors from the National Health Service Corps, physicians. The other persons on the board are community representatives from each city in the county and it is an extension of health care, too.

Senator CLARK. And what does the Rural Health Initiative bring to these communities, this area, that they didn't already have? What good is it?

Ms. WOOD. A mental health program.

Senator CLARK. Mental health?

Ms. WOOD. That was the thrust of the program.

Senator CLARK. Can you be more specific? What do you mean by mental health?

Ms. WOOD. OK. There will be a clinical psychologist available to all county residents.

Senator CLARK. That was not previously?

Ms. WOOD. Right.

Dr. MALLORY. He is available now. He has seen patients. I have referred several patients to him.

Senator CLARK. Is that a great advantage to the people of this area or not?

Dr. MALLORY. It is more of an advantage.

Senator CLARK. It is some advantage?

Dr. MALLORY. Right.

Senator CLARK. Is that the only thing that that Rural Health will do is to bring a clinical psychologist?

Ms. WOOD. No; there is also money allocated for one more physician for the county as far as physician recruitment goes.

Senator CLARK. Under that Rural Health Initiative?

Ms. WOOD. Right, right.

Senator CLARK. So that could assist you in getting another physician.

Ms. WOOD. Right.

Senator CLARK. How so?

Ms. WOOD. To buy equipment or purchase equipment to help start another—or, you know, also I think in the second year there is a nurse or a physician's assistant in the program.

Senator CLARK. So the pros of it, as I understand you, are that it has now provided a clinical psychologist for the citizens of this county, that it has the funds to provide facilities for another physician—

Ms. WOOD. Equipment for—

Senator CLARK [continuing]. Equipment for another physician and equipment for a physician's assistant or nurse practitioner.

Ms. WOOD. The salary would be for a physician's assistant.

Senator CLARK. The salary for a physician's assistant.

Now, what are the cons, or what are the negatives?

Ms. WOOD. Oh, I believe that the physicians have a role—

Senator CLARK. Well, here we have got one over here at the table.

Ms. WOOD. About the community getting too involved in the practice of medicine rather than in the administration of the—and rightly so. After 1½ years of being involved there are tendencies, you know, and we hope that those are the areas that have to be taken into consideration that the lay people don't get involved in the practice of medicine.

Senator CLARK. How do lay people get involved in the practice? I mean, you have got a clinical psychologist.

Ms. WOOD. Right.

Senator CLARK. See, I just don't understand what you are saying. I just want to be sure on the record that I understand what you mean by lay people getting involved in—

Ms. WOOD. That we just administer the program. That we don't tell the psychologist, "Gee. I think that you better go out and see that lady because she doesn't look very well that day." You know, I mean, there is a definite point of where one—

Dr. MALLORY. What she is saying is that there has been some problems in the other area of where the community board, has or various members on the community board, have suggested to the practitioner of medicine that he should see this person because they have registered a complaint with the board, or that the physician is devoting too much time to this particular patient or not enough time to this particular patient or not doing the right thing for this patient because the patient has complained to a civilian member of the board. And it gets—

Senator CLARK. I see.

Dr. MALLORY. And that is what she is trying to express.

Senator CLARK. Is that the only negative that you can think of?

Ms. WOOD. Oh, I think that sometimes when you get in on the equipment side of the grant that can be a problem, too.

Dr. MALLORY. If I may interject something there. There are other physicians in the county present. I didn't see Dr. Schaeferle over there, but there are numerous members of the Tama County Medical Society present here including Dr. Schaeferle, Dr. Havlik and Dr. Maplethorpe and myself, there is four out of what—six, eight, present. And Dr. Westhoff is there, too, so—

Senator CLARK. Well, let's take about 5 minutes and anybody who wants to put anything on the record right now identify yourself and speak.

STATEMENT OF A. J. HAVLIK, M.D., CHAIRMAN, BOARD OF TRUSTEES, IOWA MEDICAL SOCIETY, TAMA, IOWA

Dr. HAVLIK. Senator Clark, I am here wearing three hats. First, in response to your kind invitation of October 1 to Dr. James Bishop of Davenport, the president of the Iowa Medical Society.

Senator CLARK. Right.

Dr. HAVLIK. Number two, as chairman of the Board of Trustees of the Iowa Medical Society and I am vitally interested in all of the rural health program. And third, as the best and only physician in all of Tama. Dr. C. W. Maplethorpe, Toledo, Iowa, added "also the worst."

I may be prepared to make some remarks about some of the statements that were made by the preceding panelists.

Several years ago the Sears program failed utterly in building clinics to attract physicians. This just does not draw physicians.

The Tama-Toledo area is sadly in the need of additional physicians. The rural health program of the Health Providers program that is a governmental agency which is keeping me from getting a physician to come in with me as a solo practitioner or in the private practice of medicine.

Senator CLARK. How do they do that?

Dr. HAVLIK. Because in all fairness, if I am interviewing you as a recent graduate of a medical school to come into work with me, I explain the entire situation and then I say, "We have the Health Providers here which will be a part of it. It is a governmental agency." And they tell me, "Well, the hell with this noise. I don't have to put up with this kind of work. I'll go in where they don't have that." So I must admit this to him and I loose the man.

I've had three interviews in my office with physicians looking for a community. I have explained the situation to them and they just are not interested.

On the question of Iowa graduates not returning to the State, I am speaking now as a member of the board of trustees of the Iowa Medical Society and fully cognizant of what is going on at the university.

We do not have enough graduate training facilities in the State to accommodate all 190 graduates that we have each year. They must go out of the State for their training. There are two places that gravitate these people. One is California and one is the East Coast.

As our lawyer son in Tama said when he finished prep school and on to college. He said, "Dad, half of your education is after you get out of the Midwest." These students want—these physicians want to get out of the State to see how medicine is practiced with different disciplines and with different environments. And then they are now coming back to the State in greater numbers, nothing to be earth shaking, but they are.

And physicians will tend to gravitate and locate where they are trained. And to state you an example, we now have at our Marshalltown Area Community Hospital two physicians. Dr. Burke and Dr. Van Gundy are Kansas graduates. They were in the Family Practice Training program at Cedar Rapids. They are in Marshalltown. They are in the community where they were trained and they are very happy in private practice.

There is considerable concern about the lay interns in the National Health Service Corps. This is understandable and it is one of the governmental bureaucracies. Many of the smaller communities want physicians, but do they really want them or do they want them as the bandaid specialist for Sunday, Saturday afternoon, and at night? And the rest of the time they will do self-referrals to Waterloo, Cedar Rapids, the Mayo Clinic.

Senator CLARK. I don't understand what you mean there. I would think they would be more and more busy.

Dr. HAVLIK. Oh, the physicians are busy but they want them available at the odd hours when the patient can't get to their regular physicians.

Senator CLARK. I see. I see what you are saying.

Dr. MALLORY. I have been on duty for the last 12 weekends. This last weekend I took my phone off the hook and disappeared. I just went up in smoke after 12 weekends.

Senator CLARK. Just to get some time off?

Dr. MALLORY. That's right. But I'm on call every night and every weekend, every night in every weekend. I think that is what he is eliciting to.

Dr. HAVLIK. I am doing the same thing and I have been doing the same thing since Dr. Wentzien retired, my associate.

Now, he made a statement that the \$9 fee for medicare that this won't be paid back properly. Every medicare patient and every physician who renders service to medicare patients has a profile established in Washington or in the State. And regardless of what your charge is, even if their fee is \$9, their profile may be established by the usual and customary fees in the community which may be \$6. So regardless of what they charge, if the profile stays \$6, that's what it will be.

Senator CLARK. Yes, yes.

Dr. HAVLIK. And it takes a great deal of time for these papers—the bills to be processed and paid back even though it goes through the computer and all of this.

The same thing holds true for the Public Health Service under the Indian program. This is administered the same way.

Senator CLARK. We will take one or more statements just for a minute or two. We've got to break this up.

Yes, identify yourself.

STATEMENT OF ROY E. BRACKIN, M.D., OSKALOOSA, IOWA

Dr. BRACKIN. I had a letter here from Senator Clark which was written on the 7th but I received it in Oskaloosa on the 14th.

Senator CLARK. That is today; isn't it?

Dr. BRACKIN. Now since health is considered a right everyone expects it. Sometimes they pay for it and sometimes they don't. In the emergency room about half of the people could not or would not pay for the services. They expect a perfect result, if not a perfect result then someone must pay the damages.

It costs money for protection for doctor's insurance; I know of five who were charged this year \$87,000; that is over \$7,000 a month they have to pay out of their clinic for protection.

There is overhospitalization. The fact is that we have a hospital in most every county with five or six patients in it. The third parties come in and reduce the bills; cut them down whether it is Government service or Blue Shield. Now what would be the best way as you say, to provide services in the small town?

Give the doctor enough income in the small town so that he can live and you will get the doctors. The way to do it is by insurance, not compulsory, but everyone have health insurance. If income falls to where they cannot pay the premium then let the Federal Government pay it up. If income falls below a certain level, you get a refund on your real estate taxes. There is to be no third party. If the Government handles the insurance then you have what we have now in

medicare, coming in with orders: "We will not pay for this. We will not pay for that." It is regulation of practice.

Dr. MALLORY. Maybe it should be: "We will not treat for this. We will not treat for that."

Dr. BRACKIN. Then the patient has 30 or 60 days of hospitalization. Well, the first thing that happens is he gets a sheet on the top of his chart; after 12 days his hospitalization must be reexamined and justified to the utilization committee. And if it's over 12 days then you must document it and you must make sure that you are absolutely justified in keeping this patient over 12 days.

And the patient says, "Well, I thought I had 30 days or 60 days."

"No, you have to be regulated every few days." That is Federal Government insurance. Private insurance, Blue Cross and Blue Shield, have regulations too, different contracts on whether they are going to pay for office calls or hospital calls or whatever.

Senator CLARK. Right, right.

Dr. BRACKIN. Now, we really don't need any central government agency in the small towns. If you give the practitioner enough referrals, enough people nearby whom he can consult and enough income so that he can run his office and have a living; if he has to figure out: "Well, gee. I was figuring on \$15 from this patient, he didn't pay it and I've got these bills coming in. I've got to take care of my family." He is distraught. He is up working at night. His financial load should be eased by insurance so that everyone who comes in has an insurance blank which will pay the bills. Then the doctor has something to back him up.

And I think that would become a great inducement to young men to come into country practice.

Senator CLARK. All right. We are very pleased to have your thoughts on it.

Unfortunately, I planned to be in Cedar Rapids at 1 o'clock. But I do have here these forms on the back table and anyone who has anything he would like to say of any kind, however long or however short, fill them out. They are self-addressed envelopes; mail it to me. They will be put in the record here as if given just as present. So nobody is going to be denied the right to say anything you would like to say.

And with that we will recess.

[Whereupon, at 12 noon the hearing recessed, to reconvene at 2:30 p.m., in the Siever's Memorial Building, Mechanicsville, Iowa.]

RURAL HEALTH SERVICES IN IOWA

MONDAY, OCTOBER 18, 1976

U.S. SENATE,
SUBCOMMITTEE ON RURAL DEVELOPMENT
OF THE COMMITTEE ON AGRICULTURE AND FORESTRY,
Mechanicsville, Iowa.

The subcommittee met, pursuant to notice, at 2:30 p.m. in the Siever's Memorial Building, Hon. Dick Clark (chairman of the subcommittee) presiding.

Present: Senator Clark.

STATEMENT OF HON. DICK CLARK, A U.S. SENATOR FROM IOWA— Resumed

Senator CLARK. The hearing will come to order.

I am very pleased to have the number of visitors to this hearing, which is a hearing of the Subcommittee on Rural Development of the U.S. Senate Committee on Agriculture and Forestry. This is the fifth of a series of six hearings that we are holding in the State.

We have held hearings in central Iowa over around Grimes and Madrid and that area; and two locations in western Iowa up around Sioux City in a small town there, the town of Merville; and then down around Treynor, another small community just east of Council Bluffs-Omaha; and this morning we held hearings in Traer which is up, you know, just south of Waterloo, west of Cedar Rapids quite a little ways; and then we stopped on the way through to visit with the family care unit in Mount Mercy, the Mount Mercy-Saint Luke, Cedar Rapids, Family Care residency program which serves the clinic here in Mechanicsville.

The whole idea of these hearings is simply to learn more about the lack of or availability of health care in small communities, communities of this size; and to try to get a better idea of what we should be doing, if anything.

We know that there are some real problems in terms of health care in rural areas. We know that there have been some interesting solutions proposed, in some cases even undertaken, as has been the case in this community.

We found in earlier hearings in New England, particularly in Vermont, that we have got some real problems in terms of health care there that have some real application here; namely, that physician's assistants and nurse practitioners who assist the physician are not presently being reimbursed under medicare or medicaid which would make their services much easier to provide.

Second, we know that many of the small town clinics, clinics of communities of this size that have been renovated or built, have had

some difficulty in getting the money to do that. So we did pass an amendment which I offered about 2 months ago that is now law which provides for low-interest, long-term loans for small communities to begin such clinics.

Well, these hearings are going to continue next year in Appalachia and in the Southern States. As I said, we have already had some hearings in New England earlier this year. Our point is simply that we want to try in every way we can to have the same kind of availability of health care services to rural communities that we have in suburban and metropolitan communities.

That doesn't mean that there is going to be a doctor in every rural community, but it does mean that health care is going to be available, to the best of our ability, on an equal basis either in some kind of central group in a large community or a medium-sized community, or perhaps through some kind of satellite arrangement similar to the one we are here to learn about today.

So, that is really the purpose of the hearing; to listen and learn and to find out as best we can what works, what hasn't worked, what you think we ought to try.

Of course, we are relying on some people you see here and others. We are going to have two panels today who really have some experience in these areas, some very direct and practical experience and some ideas.

Now, there are a lot of ways of trying to explain the maldistribution of medical personnel in what we might call rural areas, all of them, unfortunately, a little bit deceptive, because it is hard to know exactly how to make a meaningful comparison. But let me make a couple, in any case.

We know in our State now that half of all the general care practitioners are in six counties in the State. We know that if we look at the national average that because Iowa is a somewhat rural State, the doctor/patient ratio to general practitioner is greater here than it is in much of the rest of the country. The latest statistics from the Department of Health, Education, and Welfare show that in the larger cities of this country, the doctor/patient ratio is about 1 to about 762. These are general care physicians now I'm talking about—1 to 762.

In the communities of under 10,000, the ratio is 1 to 2,500. Now, that means that we have a very disproportionate number of patients compared to doctors in the smallest rural communities. In Iowa, we have about 1 general care practitioner for each 2,000 Iowans. So, we know that we have got some shortages particularly with family care physicians. We are going to be talking about that in this hearing as we were over in Cedar Rapids, as I said just a few minutes ago.

The question, of course, is how to try to arrange a system of health care. What is the practical, efficient, effective way to bring health care to people in each of the communities or outside the communities wherever one might live?

There is a tendency, obviously, toward concentration. There is a tendency toward centralization, some of it no doubt desirable, some of it perhaps not. A tendency certainly toward specialization in the medical profession.

So that is just by way of introduction and background. We are going to have two panels today; Dr. Carl Aschoff whom I just visited with, is the director of the Family Practice residency program in Cedar Rapids and then Dr. Richard Swenson who is a physician in residency at Mechanicsville at the Mechanicsville Clinic and Hugh Lamont, a businessman who has been active certainly in community health activities here.

So since I have you in that order here, let's just go in that order. I have asked these witnesses to limit their remarks to a few minutes by way of general remarks about the nature of the general problem and how we want to discuss it. And then we will have some questions and then we'll be going on to the second panel. We are going to close this meeting at about 5 minutes to 5 so that will give us about 2 hours.

Dr. Aschoff, what's the answer to rural health care? What's your experience been and can you tie that in perhaps some way to Mechanicsville?

**STATEMENT OF CARL R. ASCHOFF, M.D., DIRECTOR, CEDAR RAPIDS
MEDICAL EDUCATION PROGRAM, CEDAR RAPIDS, IOWA**

DR. ASCHOFF. Well, first of all, Senator, I think if I had the answer to rural health care, I'd have a different job title than the one I have.

I think it should be made clear that this facility that we have here is certainly providing health care for this area, but it's not suitable for every small community in the State of Iowa.

We have a dual function. We provide education as well as patient care. I do have some feelings in this regard.

I feel that the time is passed for every small community in Iowa of a thousand people or maybe even 1,500 people to expect to have their family doctor. I think it should be passed. I don't think that under those circumstances the community is as well served as it might be otherwise. I think the physician is isolated.

The physician is alone. The physicians cannot practice the skills they have been trained to practice and I think we need to think of groups of physicians in the larger of the rural communities and I'm speaking in terms of communities of 3,000, 4,000 on up where there is a hospital in the community or in very close proximity, not with all the fancy equipment that we have in Cedar Rapids or Dr. Rakel has in Iowa City, but certainly with the basic specifics that provide the physician with the tools to apply his or her trade.

I feel that there is a place for the physician extender or whatever that title might be. I have my own personal hangups yet about having that extender practicing alone in a rural area with exceptions perhaps in those parts of the country that are extremely isolated, Appalachia, the far Northwest, Alaska, et cetera.

In Iowa, there has been some situations where that might be appropriate. I mean, we have to cease thinking in terms of how many miles a person is from a physician, but how many minutes a person is from a physician. And if any person is 30, 40 minutes from a doctor, I don't think that is all that bad. That's pretty good. We have a good highway system.

I think the doctors need to rub elbows with doctors. Doctors need the stimulation of other medical minds or they become stagnated and they cease to function effectively and efficiently.

Most of the young physicians that I have helped train don't want to practice alone. And I've done it both ways. I have practiced alone and I have practiced in a group. I would never practice alone again. That's a terrible way to live. Your family suffers and I'm not sure the patients are that well served either when you are overly tired and overly fatigued and can't get away to refresh your mind.

I think that if we can be patient—and I know the people in rural Iowa have been for years, but I firmly believe this. In order to give us time to get these young family doctors who are not in training through the pipeline, I think that rural Iowa—I'm talking in terms of communities of 3,000 on up—are probably going to be better served with well-trained, competent physicians than Cedar Rapids is, for example.

And up to this point in time, the statistics bear that out. Two-thirds of our doctors that graduate have gone into communities of less than 2,000 people.

Senator CLARK. And you say in absolute figures as we discussed in Cedar Rapids that you've had—

Dr. ASCHOFF. Sixteen graduates.

Senator CLARK. Sixteen graduate residents. And 1 of these is still in the service, 10 of them have returned to communities of under 10,000, 5 of them have not.

Dr. ASCHOFF. That's correct.

I'm finished. Thank you.

Senator CLARK. Well, that gives us a good start and we'll have some other questions on it.

Let's go to Dr. Richard Swenson who is a physician in residence as I understand it here in Mechanicsville Clinic.

STATEMENT OF RICHARD A. SWENSON, M.D., CEDAR RAPIDS FAMILY PRACTICE CENTER, CEDAR RAPIDS, IOWA

Dr. SWENSON. Just to add another comment to the thought that was just finished about the 16 graduates we've had so far, out of those I can only think of 2 that have gone into solo practice out of 16 and those 2 are from Cedar Rapids in a large community where they have a lot of backup coverage and they don't have to be on call 24 hours a day.

I can't think of any 1 of the 16 that has gone into solo practice in a small community. I don't know if Dr. Aschoff can think of any.

Dr. ASCHOFF. I'm not aware of any.

Dr. SWENSON. All of these have joined groups.

Senator CLARK. In other words, they have gone to small communities but they have gone into group practices, not as solos?

Dr. SWENSON. It's not so bad if you want to be a solo practitioner if you are in a large town because there you can arrange with other solo practitioners to cover for you and you have the emergency room staff who is there 24 hours a day to cover for you if you want to go to some function at night. You can just have them check the patients.

Just a little background maybe for you Senator and for the panel, too. I think it is important to point out that this concept of family practice is not very old. It's only 4 or 5 years old where we've been having the residencies and prior to that time there was a real crisis in the field of general practice. I don't know exactly what statistics

show, but there were only 2 or 3 or maybe 4 percent of graduating medical doctors that would go into general practice.

In other words, they take the internship and then go out into general practice. However, since the idea of the family practice residency has come about, it has really turned around tremendously and it is probably somewhere between 15 and 20 percent, in some schools as high as 25 percent, that are going into family practice.

It has a new sort of prestige associated with it because now we are supposed to be a specialty just like anybody else. So now the medical schools are coming to where even though they don't really wholeheartedly support it, at least they tolerate it a lot better than general practice. So I tend to agree with Dr. Aschoff that things are going to improve for rural America across the United States because as these family practitioners are being trained, by and large, they are not staying in the big towns because the big towns are just saturated with specialists and this isn't the area that most of us are interested in. It isn't the area that is most inviting to us.

The best places for us to go are the smaller towns. But I can speak from a person who is at that point right now and looking where he wants to go. I don't think that there is going to be 1 percent of the graduating family practice residents that are going to move into a town that doesn't have a hospital there. It just doesn't pay. I mean, it's one of those minor aggravations in life to have to travel 10, 15 miles several times a day or to deliver your OB's or something like that to go to a town that doesn't have a hospital.

That is one of the things we want, a facility where we can hospitalize our patients. Now, there are doctors in Mount Vernon, and there are doctors in Tipton and there are no hospitals there, but those are the doctors that have been there for quite some time. And I don't think you'll see new doctors going to those towns.

Another thing Dr. Aschoff mentioned is we weren't going to small towns where there aren't any other practitioners that we can join in a group situation for the on-call coverage. In other words, so we won't have to be on call every night, 7 nights a week, 365 days a year. And I think everybody here can understand that. I know you wouldn't want to put yourself in that sort of situation either for a lot of reasons, just because you become overexhausted and also because as Dr. Aschoff mentioned, the family suffers. And just the prospective is changed as opposed to what it was 10, 20 years ago.

Also, the issue of professional isolation. You just don't want to isolate yourself in that way. It's been interesting for me to reflect on the evolution of my own career when I started out in college and decided to go into medical school. I was absolutely the prototype of somebody who wanted to be a small town solo general practitioner.

Senator CLARK. Had you come from a small town?

Dr. SWENSON. I came from a town of about 10,000.

Senator CLARK. I see.

Dr. SWENSON. And that's exactly where I wanted to go to, maybe a town of 1,000 or 2,000. And I don't think there was probably one person in a thousand that was more dedicated to that goal than myself. But I changed. And I think that is going to happen to every single student. He may start out with that idea in mind and I think he's going to change.

Now, I'm going to be going to a town of about 12,000, but it's got a group there and I'm going to join the group.

There have been different special incentives offered for doctors to go into underserved areas such as forgiveness of student loans and so on. The Federal loans that many doctors have to rely on in medical school, there was one statistic I saw recently that 75 percent of medical school seniors are in debt \$9,000 or more. So we have to depend on the Federal Government for a lot of these loans; and there is this incentive that the Federal Government would forgive a percentage of that loan for every year you were in a rural area. But I don't think that that's been very helpful in attracting doctors to these areas.

Senator CLARK. I might say we just looked at one. It was a National Health Service Corps doctor that you are speaking of?

Dr. SWENSON. Yes.

Senator CLARK. They have two doctors in a new clinic in Traer and one doctor in a clinic in Toledo. In other words, these are three doctors that come to this particular county; and although there are some bureaucratic problems with it, they tend to feel that it's been relatively successful. We'll send you a copy of the hearings and you can read about it.

Certainly if it's an answer, it's only a very small part of the answer.

Dr. SWENSON. Do they intend to stay there?

Senator CLARK. They say they are going to stay. One of them has only been there about 16 months and the other one only 6 months so we'll have to see.

Dr. SWENSON. As far as paramedical practitioners, I think there is a place for them. As to whether they should practice on their own, I just haven't decided. As far as nurse practitioners or physician's assistants, I think the best place is practicing in doctors' offices where the doctor is just seeing too many patients and is overburdened. And if there are two or three doctors there, I could see that. But if I was a physician's assistant or even clinical pharmacist who fit in this area, I don't think that I would want to practice on my own. There's just too many mistakes that can be made.

I think of myself, the anxiety I've felt at times, and I've had 7 years of training and pretty good training, and yet there's so many times there are questions in your mind as to a diagnosis or what you should do. And I can just foresee that they could make a lot of mistakes if they were unsupervised.

And if this idea that I have is proven wrong, then I'd be the first to say I'd be all for it. But if you just make one tragic mistake every 5 years, I don't think it's worthwhile. And plus with the medical-legal situation that we have now, I just don't know how this is going to work out.

Senator CLARK. And certainly if you did have a physician's assistant or nurse practitioner, it would have to be done in very, very close and constant association with a doctor, a physician; wouldn't it?

Dr. SWENSON. Now, there are strict protocols that they are working under, that could work in order to minimize the possibility of these people making mistakes in diagnosis. A nurse practitioner that's looked in a child's ear can recognize many things as well as I can. I mean, they have looked in many ears, maybe more. But it's just some subtle things that their training doesn't allow them to identify. And right here in our own office we have pharmacists and they do an awful lot of

things for us and follow up on blood pressure and it saves us a lot of time. I don't know how comfortable they'd feel entirely out on their own; if it was me I just wouldn't feel very comfortable if put in that position.

Senator CLARK. Good. Thank you very much.

We're going to hear now from Jerry Lamont. I know you've got some interest and knowledge of what's happened, Jerry, in Mechanicsville in terms of health care and so forth, so you just proceed in any way you think appropriate.

STATEMENT OF HUGH G. (JERRY) LAMONT, COUNCILMAN, CITY OF MECHANICSVILLE, MECHANICSVILLE, IOWA

Mr. LAMONT. Well, thank you very much, Senator.

First of all I would like to, as councilman, officially welcome you and your staff to our community. We're very appreciative to have you here.

Senator CLARK. Thank you.

Mr. LAMONT. And also to thank the people who have come today. I'm going to try and address my remarks to the building of rural health systems which I notice is the title of the pamphlet which I picked up in the back of the room which I've had just a few moments to glance through.

I might mention that 4 or 5 years ago after the passing of Dr. E. H. Littig who was our resident physician for a good number of years, we felt a very sudden and acute need for health services.

I think the first thing that happened was Dr. Littig's family tried to see if there wouldn't be someone who would be willing to take over his practice. They were rather unsuccessful in the attempt that they made.

Several months which grew into years passed and through a great effort, I would say, on the part of a good number of civic minded individuals and groups, it looked as though we were faced with a rather impossible task of even beginning to attempt to replace the services that we were used to for so many years under Dr. Littig.

It was at that time that I had a meeting on a very cold winter morning with Dr. L. Robert Martin who is the former doctor to the position Dr. Aschoff now heads. We met at the corner up at city hall and kind of grinned at each other and spoke for a few minutes about what was a seemingly impossible task of providing rural health care, the involvement of the Cedar Rapids Family Practice Residents in our community. We kind of smiled and shook hands and left that cold day knowing that while it seemed impossible, some way by golly we are going to get the job done.

So with a great deal of community effort, a great deal of effort by the staff and administration of Cedar Rapids hospitals, a series of meetings, a series of strategy sessions, we sat together in building rural health systems, a plan that would work for Mechanicsville.

We agreed upon certain areas of responsibility. We had a building or a facility, if you would, which formerly—a portion of which had housed the former general practitioner's office. This was, however, entirely inadequate and it was necessary that a certain amount of money be raised for them to be remodeled and be made suitable.

The Cedar Rapids people agreed that they would provide us with the people to run our doctor's office if we could provide the office structure physically. At that point, there was a great deal of civic interest and a very large ground swell of personal interest by people not only in the city limits of Mechanicsville, but in our neighboring communities.

We did launch a fund drive which we raised a little bit over \$30,000 which enabled us to remodel the facilities to a suitable state. About 2 years ago in July, about roughly 6 months after we first met and talked with the people from Cedar Rapids, we had her open.

Two years have passed since that time I have been involved in health planning in general, serving on the former Hoover Health Council, we realized that health services in general are not limited to necessarily a doctor, a residence, an office in a small community. We have since probably opened a Mechanicsville Care Center facility which opened approximately 2 years after our pioneer health center just this last July.

I think that the current community use and benefits of our pioneer health center here are just so wonderful and overwhelming that I'm sure I speak for the literally thousands of people in the Mechanicsville community area and surrounding communities which without these services—and I might add it's been an educational process for us as well as those people who have been serving us.

I don't think we realized what good health service could be until we really got involved with these people. They seem to me to be above and beyond the call of duty. They seem to provide us and anticipate problems which we might otherwise neglect. And it is again with a great deal of thanks from the community that I would like to thank you two gentlemen and your staffs for what you have given us. And I hope there will be a continued relationship working well from both sides of the street and working both ways.

Senator CLARK. Good. Excellent.

Let me start with questions with you because I want to get a better idea of when this started exactly and what your needs were.

You said that the former physician died and you've got what, about 1,000 people in this community within the city limits?

Mr. LAMONT. That's correct.

Senator CLARK. But then several hundred around.

Mr. LAMONT. We did some statistical work along the lines of that. A thousand people or so that we had living within our city limits would not support the system. We did at that time have an area health planning agency which has since ceased to exist and be absorbed by the larger statewide area planning agency that provides us with a great deal of statistical background as to what age groups of people and sheer numbers in townships that we would have to work with. And I think we came up somewhere in the neighborhood of 3,000 or 4,000.

Senator CLARK. That would be served by this area?

Mr. LAMONT. That Dr. Aschoff mentioned earlier. And I think if we could not provide them with this statement of statistics they would. And I think there are quite a few people locally who made contacts with them and urged and pleaded, I guess you might say, "Please, give us the place you tried to locate in."

Dr. ASCHOFF. I would like to correct the record, if I might. It was 3 years last July, not 2.

Senator CLARK. Now, this, I guess, is really addressed to all three of you. How does it work? Do you have somebody out here full time or part time or how does the system work?

Dr. ASCHOFF. For our program we have a third year resident in his last year of training who lives in the community. We're renting a house. We recently have purchased a house we're going to be moving the first of January and the resident moves here with spouse and family and they live in, so to speak.

Senator CLARK. And that's what you are doing, Richard? Do you go by Dick or Richard?

Dr. SWENSON. Dick.

Senator CLARK. So you are the resident here now from the third year and there is no one else here. It's one physician here?

Dr. ASCHOFF. But they rotate, Senator. They'll stay here for 2 months, maximum of 3.

Dr. SWENSON. 3 months. I'll be here for 3.

Dr. ASCHOFF. We supervise it part time. We do not have faculty personnel here all the time. My feeling is that at the third year level, it isn't necessary. But we do supervise it part time. But the resident moves in with the family and hopefully becomes part of the community. We feel that it's important to gain the flavor of a rural community while they are here. And I think the community has welcomed them and they have become part of the community.

Senator CLARK. But you or your faculty do come down here then and do help in supervision?

Dr. ASCHOFF. That's correct.

Dr. SWENSON. The third year residents are fully licensed by the State of Iowa. And I could quit the program and keep an office anywhere in the State of Iowa. I could have done that 1½ years ago already. So some people wonder about the idea of supervision. I really don't think that it is necessary. By the third year, at this stage, I think we are pretty competent physicians.

Senator CLARK. Let me go back to Jerry for a minute.

Now, what do you think, what does that do for you that you wouldn't otherwise have? Suppose it weren't here.

Mr. LAMONT. I think first of all I'd like to speak to that question from this concept that as a small hub or business community, certainly the provision of medical service here bring people into our community as opposed to going somewhere else. So as a businessman, I can very much sympathize and say that it's a wonderful thing for the business community.

I think that, second, it provides a means for people in our educational system to have better health education because these people have been very good and very dedicated in addressing themselves to the problems of people of the younger age brackets. To flip that coin around for a second, they also have gone into the community of the senior citizens which we have a very active group here, spoken with them. They have also attended many of the service organization functions which would have been held here and in general, given us a better education of what we might expect of ourselves in regard to maintaining our own health care, specifics as well as generally. Some danger signs to look out for in many areas of disease.

These things we would not have had otherwise.

Senator CLARK. All right. Well, I think that's a proper emphasis, in particular, the health education, preventive medicine, and that kind of thing.

The thing that you are sort of torn on in this, and I hadn't really thought much about it until I heard what Dr. Aschoff said and you're saying, is that there is a kind of contradiction at play here that's hard to resolve. On the one hand, one might make the argument from a mental point of view, a point of view of providing quality health care, that it's not so important to have a doctor, a physician, in the small community; in other words, if it's accessible to some place else.

On the other hand, you're sort of making the point, too, that to have the physician there is lending something to the community in and of itself. I suppose this is the same kind of growing pain, in a sense, that you have with other community facilities, such as the consolidated school.

When the community loses the school, it loses something of the community. As each of these things are drawn away from the local community, it does lose a little more of the sense of community which we've always argued, and I think justifiably, is important in the sense of the value structure of the system. It's a hard thing.

Mr. LAMONT. The proximity and the sensitivity is extremely important. And as I said, I feel that we did, in a way, reach an impossible dream in having the type of staff and personnel and facility here that we have today.

Senator CLARK. Yes.

Mr. LAMONT. Obviously, it cannot happen in very many communities like us. I would like to take this thought for those communities who are not able to achieve this type of thing and in hearing what these gentlemen are saying and weighing reality when our wishes might be—it reminds me of the old saying that 50 percent of something is better than 100 percent of nothing.

And we do have transportation means today; for example, we can have someone from here to one of the hospitals in Cedar Rapids in something, I think, probably less than 30 minutes with our local ambulance service which is voluntarily run, too.

Senator CLARK. Are they trained?

Mr. LAMONT. Very highly trained and highly certified. Again, we are very fortunate in having the unit and the kind of people in the community who are willing to give their time and effort to provide this type of service.

Senator CLARK. That's the thing. If you are going 20 or 30 or 40 minutes away from the hospital, you do need this good emergency vehicle and trained people to get people to the hospital.

Let me ask, just to get it on the record here, the two doctors—just three or four quick questions all of which you've touched on. But I'd like to get just a little more information because I think it's essential to the committee, particularly, understanding it.

Both of you made the point a couple of times here about solo practice, the difficulties of solo practice. And I gather that you are talking here about the advantages of having two or three things: immediate consultation, professional consultation with one another on diagnoses and other such things. I gather you are talking about the ability through a group practice to have some time off to improve your

profession, as you said, to read, whatever, to go to medical meetings; for vacation, for time off so that you can be more effective and sharper in your occupation.

Is anything else involved other than those two factors, professional isolation and is that about it?

Dr. SWENSON. Call coverage, as far as being on call. That's a main thing, too.

Dr. ASCHOFF. I think it's also essential that we must realize that the physician's spouse also needs to be happy where they're living. And most physicians are males. We are getting more and more females all the time, but the spouse is usually the wife and she has to be content. She has to be satisfied that her life is meaningful. I'm not saying that life in a small town is not meaningful, but she has to appreciate this. She has to be satisfied that there is ample social outlet for her other vocation, if she has one of her own, that there is ample schooling for her children.

Maybe she is bold and determined her daughter is going to take ballet or what not. They have to be happy. If the spouse isn't happy, the doctor isn't going to be happy. We don't all march to the same drummer.

Senator CLARK. So it is social, cultural isolation consideration as well as professional?

Dr. ASCHOFF. That's right.

Senator CLARK. And then just a little more on the question of the hospital because I have heard this now over and over and over. I gather now that what is happening is that physicians are not trained to operate just out of the black bag as they may have been to some degree say prior to World War II. Those facilities are really necessary to give quality care; is that a fair assessment?

Dr. ASCHOFF. I think so. I just don't think we can take a physician and train him or her for 7 years and turn out what we deem to be a finished product, a competent product, and then ask him to take up their black bag and fly by the seat of their pants.

Medical science is not that any longer. Medical science is very complicated. The rapidity of which our knowledge becomes outdated is absolutely frightening. And I think that the physician today and the physician's patients, I think—we must not forget the patient—is entitled to the very best of care that we can provide and that we can afford. And I think to isolate a physician without the benefits of at least the basic essentials of laboratory services, X-ray services, ancillary personnel, for example, other pharmacists, that we have here—those are tremendous assets to the physician and without these I just don't think you can practice the quality of care that we are training them to practice.

Senator CLARK. So that if we could, by some magic wand, provide a physician for every community in the State—I guess there are 950 communities or something like that—it's doubtful, in your judgment, that the rural people would really get the quality care that they ought to have in any case?

Dr. ASCHOFF. I don't think they would, Dick.

Dr. SWENSON. I tend to agree with that. There is one simple example here. We don't have a chest X-ray unit. We do have an X-ray machine, but we can only take X-rays of extremities. There are many times when I just sit there and I say, "Should I get an X-ray or not?" The patient doesn't want to go to Cedar Rapids to get it and you get

somebody who is 50 years old, a smoker, and has a cough. He might have a tumor in there, and if you don't get it done and the cough goes away and you pick it up 6 months later, it's probably too late. So a lot of times we sort of slide by on these tests.

A little baby who is sick. We can't do white blood counts in our office. We just skip it and maybe you're missing the meningitis and the next morning he is really sick. So if you are practicing in a bigger town, you tend to order them right away and you don't put it off.

Senator CLARK. That's a good example.

Dr. SWENSON. And I can't practice optimal medicine like that. And I don't mean to keep bringing up defensive medicine, but that is just what we have to practice in the midst of today. And it is a very important factor. And I don't think we can deny it. We just have to practice defensive medicine to a certain extent, and it just increases your anxiety level when you are out in an area like that, when you are away from those laboratory tests.

Senator CLARK. So what you have to do is just make the best judgment you can of whether we have to go into Cedar Rapids and have those tests.

Dr. SWENSON. Yes.

Senator CLARK. Let me ask you a more delicate question. Are financial considerations important in deciding to go to a smaller community as compared to a larger city; or is it about the same either way?

Dr. ASCHOFF. I don't think it is a major consideration.

Senator CLARK. You agree with that?

Dr. SWENSON. There are some doctors in smaller towns that are making twice as much as the doctors in larger cities.

Senator CLARK. So it is not a financial consideration. You can make, I assume, a good living either place.

Well, now let me ask you what I think are more delicate questions because you are both—all three of you are very articulate. And I have got two or three dilemmas in my own mind after hearing four of these hearings.

The first one is the value of physician's assistants, and I have noticed that both of you have some feelings that apparently they may have a place in this whole picture. And yet there is a certain reluctance. Let me try to put the case as strongly as I can, as I have heard it from physician's assistants and start from there.

It does seem to me that for most kinds of health care, as you say Dr. Aschoff, you can be within, I think, 30 or 40 minutes of that care being provided and perhaps provided in a facility where you can really take the tests and so forth to bring the kind of quality care. But wouldn't it be true that you would have a greater advantage of living, in certain emergency cases, if indeed you had, let us say, a well-trained physician's assistant in a satellite clinic to take care maybe of a heart attack case or something of that kind?

Dr. ASCHOFF. I think that is true. There are those rare instances, but I don't think they are very frequent. And I think, as I said, I have trouble coming to grips with this and I know there are people that disagree with me and I respect their views. People who have published reports, particularly in the Appalachia area, probably are more aware than I that they work very well without the daily communication with their physician.

I think that there is a place for it. I look back in my 20-plus years of practice and I did an awful lot of things for a lot of years, things that someone else could have done as well or better.

Senator CLARK. With less training?

Dr. ASCHOFF. With less training, who is not as expensive as I am. I am an expensive commodity. And if I were going back into practice today, I would want a physician extender of some sort because I think they can take the monkey off my back. All I want to do is put my feet upon the desk, maybe, and read while they do some of the work. But that isn't bad, either. But I still have trouble having them operate independently.

They say, you know, that 80 percent of your patients are going to get well whether we treat them or not, and that is probably true, and 50 percent of the things the family doctor does, someone with less training could do. But those are all retrospective thoughts. You discovered that retrospectively. You don't discover it at the time you are seeing the patient. It is only after the instance is over with that you realize that this patient was going to get well without me, or this patient is going to get well if I saw him or the extender saw him. But at that moment in time, you have got to be able to see that.

Senator CLARK. And so what about the idea of physician extenders and nurse practitioners in terms of helping you, let's say, out in the nursing home or something of that kind?

Dr. ASCHOFF. I think they can play a role, Dick, we do here; don't we? Our clinical pharmacists, play a very definite role in the care of your nursing home patients here.

Senator CLARK. We had a witness who said that they felt that by having a full time extender—now this wouldn't apply to Mechanicsville, but in a satellite clinic—sometimes you could detect an illness earlier. People who had routine kinds of care would be more apt to come in than they would to get in the car and drive 30 or 40 miles and thereby get somewhat more regular or instant care and that indeed even on some of those visits you do discover some things that they are not aware of.

Does that sound at all possible to you?

Dr. SWENSON. I think that is true. We have patients living right behind the clinic that have trouble getting in and they say, "Why don't you drop by the house going home." But they are the elderly patients that have trouble getting around and I can appreciate that. If they had to go 20 minutes, boy it would be like pulling teeth to try to get them down to the doctor's office. Not that they would rather sit and suffer, but the alternative is something they don't want.

Senator CLARK. Particularly if they can't drive or don't drive a car or something.

Dr. ASCHOFF. One point I would like to make for the record is that, that is, however and whatever setting the physician extender is going to have will depend—we have to find a reimbursement mechanism and this problem certainly is far from solved.

Senator CLARK. Exactly. And that is going to be one of our major undertakings, to try to get these people reimbursed under medicare and medicaid so that we can afford to have them.

Dr. SWENSON. I would like to go back to one question if we could, to the idea of emergency and the role that the physician extender might have in that.

I really cannot foresee any emergencies in my mind that a physician's assistant or something else is going to be that much help for. If you are talking about a broken bone or something like that, it doesn't make that much difference, 30 minutes. We take a lot of them here, but if it is a serious fracture I can't see that they are going to intervene.

A car accident, they possibly could stop some bleeding or something like that; but a heart attack, I don't think there is anything they would be able to do. I don't think there is anything that I could do out here in Mechanicsville if my neighbor had a heart attack.

The survival rate of heart attack is directly related to how soon that person can get to a hospital and defibrillator if he needs it.

Senator CLARK. Isn't there a point of getting the heart beating again that you could do, for example, or a physician's assistant could do in some cases where if they had to go to the hospital it would just be too late?

Dr. SWENSON. Well, I really don't think there is. If a patient is in asystole, which means the heart is actually stopped, there is not that much you can do. If you give some intervenous medication you might be able to reverse it but the incidence of reversing it is very slim. And if they are having a rhythm problem, you have to have sophisticated equipment to do anything about that.

Senator CLARK. I see. You couldn't do anything, anyway?

Dr. SWENSON. And most of the emergency medical technicians, ambulance drivers and so forth are not given the license to do that anyway now, and we don't even have a defibrillator in our offices now.

If a patient had a heart attack, sure I'd go over and see him as quickly as I could; but the most important thing is to get him to the hospital as quickly as we could.

Senator CLARK. Well, let me try to ask you an even more difficult question, Dr. Swenson, and there is no answer to it, I suppose. But it seems to me that in this kind of respect, as Dr. Aschoff said, you have got this question of how much education you need to do a certain thing, and admittedly, a lot of it is retrospective in the sense of having diagnosed and said, "A physician's assistant could have handled this." But isn't the same argument really used against you as a general practitioner; namely, that the specialist says that you don't want to deal with these general practitioners. They are too thin.

They have learned about all these things. And if you really want quality health care, what you have got to do is always go to a specialist. I think you and I wouldn't subscribe to that idea, since there is a level of education in which you are perfectly capable of doing a great number of things, perhaps not everything. Well, certainly not everything.

But in other words, isn't it possible to view that there are some things for which you do have to have a specialist, and there are some things that a general practitioner can clearly do as well as a specialist. There are certain things that a physician's assistant or a nurse practitioner can do that are equally good. Is that a fair enough way to look at it or not?

Dr. SWENSON. Well, I think it has some validity to look at it that way probably, but just take an example again. Hypertension, high blood pressure. I mean, it is a very, very common problem and it seems like 55 percent of the people in this town have hypertension. With the

help of the clinical pharmacist I'm just amazed at how well we are taking care of it.

Senator CLARK. Is the clinical pharmacist here?

Dr. SWENSON. Yes, Jan is here.

Senator CLARK. Great.

Dr. SWENSON. And that would be easily treated and dealt with under a protocol situation. In other words, the patient comes in, you can take their blood pressure. If it is still elevated, you add another pill. And you could provide a protocol for that whole thing.

But so often a patient will come in and we will take their blood pressure and they will ask about an aching leg or they're in distress and they will talk of something that makes me think of gall bladder. Seems that 60 or 70 percent of the hypertension visits are not just uncomplicated hypertension. So many things that you have to talk to the patient about. So even these simple problems that sound so simple and could have been dealt with under a protocol situation often there are little offshoots, little slips of subtle things that you pick up.

And a lot of times our training differs from that of a specialist. Well, for example, a person has a blockage in their carotid artery and I know how to pick that up and I know a lot about the disease, but I don't know how to do the surgery. Now, whether you could really help a physician's assistant to understand the different subtleties about how to detect that and how to listen for a bruit; I don't know.

I think the specialists are just more trained in techniques and procedures. For instance, an obstetrician. I think I have almost as much diagnostic knowledge as a obstetrician/gynecologist. They certainly do know a lot more of these different things; for example, how to treat cancer of the cervix. I can detect it and I can see it, but then I send it to him for him to treat. But whether these other ancillary personnel could come to that same knowledge of how to recognize and pick up these things that we are trained to have; I don't know.

Senator CLARK. Good.

Well, I must say you are a very articulate physician and I'd be happy to have you as my doctor, I'll tell you that. I sure would.

Dr. SWENSON. Are you going to move to Mechanicsville or should I move to Washington?

Senator CLARK. Well, I move around a lot. I may just drop by occasionally.

I wonder, just one last question. I don't know whether you have had a chance to think about this a lot, but what is the proper role of the Federal Government in all of this as you see it? Do we have any role to play and if so, what is it?

Dr. ASCHOFF. Well, I think you have to assume a role and I differ from some of my medical colleagues in that matter.

I have my own personal feelings that a lot of the quote physician shortage unquote today is a maldistribution by specialty and a maldistribution geographically.

The former problem of maldistribution by specialty, the medical educators and the medical schools have certainly not shown up to this point in time that they are capable or willing to redirect their efforts in the area of training primary physicians without extreme stimulation and arm twisting by the Federal Government. They have been very reticent to doing that on their own.

The maldistribution geographically is another matter. I feel sorry, I truly do, for people living in the inner city. I don't want to live in the inner city because I don't want my family to have to be raised in the inner city and yet I think these people are entitled to access of a health care delivery system. I don't have an answer for that. I don't think anybody has an answer for that.

We think we are bad off in rural Iowa. Even the rural Iowans are living in a paradise compared to what the people are in the inner cities. But to conscript full physicians and say, "You are going to practice in that area for a given period of time," is certainly contrary to the American way of doing things. And I don't know what the solution is.

All the efforts that have been tried up to now have been pretty much in vain. I guess we have to get rid of our inner cities and I'm not sure you or I are going to live long enough to see that take place.

I think the Federal Government has to assume a role in funding. No question about that. I just don't think that the private sector can provide the necessary funds to train physicians, physician's extenders, that need to be trained.

There are those who feel, however, that we are going to have too many physicians in a few years. And there is no evidence to support their view; however, the unknown question at this time is what further demands are going to be made on the system with some form of national health insurance which I think we all agree we are probably going to have.

I think the Federal Government has to play a role, Senator. We oftentimes throw brickbats at the Federal Government and I certainly have been one to throw brickbats at the Federal Government, but at the same time, I don't think that we would have the health care delivery system we have or the physicians that we have trained without the Federal Government. I don't know where the dollars would come from.

Senator CLARK. In terms of their help in your residency program.

Dr. ASCHOFF. I have a Federal grant.

Senator CLARK. In training these young doctors.

Dr. ASCHOFF. That's right. I'd like to have more money than I'm getting, but I'm not going to refuse what I'm getting.

Senator CLARK. Thank you very much. You've been an excellent panel and we really appreciate it.

We are going to hear next from Dr. Robert Rakel and Dr. Richard Cook and Jim Coulter from Williamsburg. Come right on up.

We are pleased to have you here. Let's see. I've got on my list Dr. Robert Rakel, you'll be first and then Dr. Cook and then Jim Coulter.

And Dr. Rakel, we're particularly pleased to have you here because I know that you direct the Family Practice Residency program at the University of Iowa. And of course, if we're really going to get physicians in the more rural areas, it has to be family practice and so that's where the action is. Tell us about what is happening.

STATEMENT OF ROBERT E. RAKEL, M.D., DEPARTMENT OF FAMILY PRACTICE, UNIVERSITY OF IOWA, IOWA CITY, IOWA

Dr. RAKEL. Well, if I could, Senator, I'd like to give a brief overview of what's happening in the State and then let my colleagues handle the more local situation. To begin with—

Senator CLARK. Great.

Dr. RAKEL. We have a statewide network of seven affiliated family practice programs. This network was established with some purpose, mainly because studies have shown that physicians, after they finish their formal training period, practice within 100 miles of where they have taken that training. One of the problems in the past has been that most graduate education has occurred around medical centers; and so consequently physicians continue to locate their practices in these areas. This is just the opposite effect required to satisfy the rural need.

Fortunately there are towns in Iowa that are located fairly evenly throughout the State and are large enough that we could situate residency training programs in their hospitals. We now have evenly distributed around the State seven different programs.

Senator CLARK. Can you list those for us?

Dr. RAKEL. Yes. There are two in Des Moines, one in Sioux City, one in Mason City, one in Davenport, a new one started in Waterloo, and then the program in Cedar Rapids fills out the State pretty well. By establishing residency training programs throughout the State and having the residents spend 3 years in these communities after graduating from medical school, we hope to motivate them to stay in that area.

After 3 years they are going to feel comfortable with the community. They are going to know the area and learn to enjoy it. One of the reasons why physicians didn't locate in rural areas in the past has been the lack of opportunity to identify with or really understand the rural communities.

We've had residents from downtown Chicago who matched with our program and were just amazed at how nice rural Iowa was. They would never have had the opportunity to even see it, much less learn to appreciate it, had they remained in Chicago for their training. Much of the physician shortage problem has just been a lack of exposure and a lack of involvement.

Since the department began at the medical school, 6 years ago, we have developed the seven programs into an affiliated network and all of them interact with the university in one way or another.

The number of residents has grown from zero back in 1971 to 128 residents in training throughout the State at the present time.

Senator CLARK. One hundred and twenty-eight?

Dr. RAKEL. One hundred and twenty-eight. We are graduating 38 this year in the State of Iowa. We hope to, when all programs are fully functioning, to be graduating close to 60 residents per year.

We've made some projections on what the needs of the State are. They differ a little bit from your earlier figures and we'll be happy to compare them with you.

Senator CLARK. Good.

Dr. RAKEL. The State of Iowa has continued to lose family physicians steadily over the past 20 years. That trend turned around 2 years ago for the very first time, and we are now gaining on the problem.

A physician-patient ratio has been established at one family physician per 2,500 individuals. Now, that is a national ideal which really doesn't apply to Iowa. Iowa would do better with one family physician to every 1,800 or 2,000 individuals. We calculated the number of

physicians who would retire or die and the number who would complete their training in the State.

We calculate that by about 1986 we will achieve a ratio of about 1 to 2,500. So far our projections have been fairly accurate.

Senator CLARK. Is that ratio fairly adequate, in your judgment?

Dr. RAKEL. No; I really don't think so.

Senator CLARK. You were thinking to get it down to—

Dr. RAKEL. It is 1 to 1,800 or 2,000. The reason is the 1 to 2,500 ratio is based on consultants being available, whereas, in rural Iowa, the family physician is giving the anesthetic or doing a variety of things that may well be handled by additional physicians in larger communities.

At the same time, as a result of our having a department, the student interest is about doubled at the university. We had about 26 percent of the entering students in 1970 that were interested in family practice. For the last 4 years, this figure has been about 52 percent. So in 1972, for the first time, more than half of the students entering the school were interested in entering family practice.

Senator CLARK. Do they come out with that?

Dr. RAKEL. No. Almost no school in the country maintains this level of student interest because their entire exposure during that period is to nonfamily physicians. One of my reasons for being really interested in starting a department was to change that and offer some role models as well as some courses that truly teach what family practice is.

The University of Iowa is unique, however, in that it has maintained student interest to a much greater degree than any other school I'm familiar with. At least, for several years 26 to 32 percent of the graduating students did go into general practice or family practice.

Senator CLARK. Do you have any average over the last 2, 3, 4 years?

Dr. RAKEL. Yes. It has been averaging about 30 percent who go directly into family practice residency programs over the past 3 years. The figure is actually larger than that because a number of students will go into a 1-year rotating internship or some other experience and then end up doing family practice. So we think it still totals about 40 to 50 percent; and that is unique for medical schools in this country.

Senator CLARK. You think that among graduates in the last 3 years that perhaps as many as 40 to 50 percent end up in family practice?

Dr. RAKEL. Yes. Let me give you the exact figure for Iowa medical school students selecting careers in family practice. Last year the total was 31 students out of a class of 148.

Senator CLARK. Only 31 out of 148.

Dr. RAKEL. So the final percentages we really can't tell yet but I would expect it is going to be close to 35, 40 percent. At least, that's the way it happened in the past.

Let me go on if I may—

Senator CLARK. Sure, sure.

Dr. RAKEL [continuing]. To talk about the motivating factors we use. We require our residents, at the university, to take a month of preceptorship during their second year in a practice in Iowa, almost always a rural practice situation.

We have two purposes in this. One is, much of our third year is elective, so that the resident selects what he wishes to in the last year. But the required second year preceptorship forces them to get out

into a rural Iowa community and see whether they like it or not. And we hope that in this manner we will be successful in enticing more residents to practice in Iowa. And fortunately, out of our first year's graduating class, students from outside the State who were attracted here for training selected small towns in eastern Iowa to practice. Two of our best residents went into towns of 2,000 population to practice. And their States would have loved to have them back.

Senator CLARK. Do you remember the communities?

Dr. RAKEL. Oh, yes. One is Lone Tree, Iowa.

Senator CLARK. I used to live there. I know where that is.

Dr. RAKEL. And the other is Fairfield. We have another resident who went to Osage but he is a native Iowan, as well.

That month in the second year at least gets them out and exposes them to a rural area. We have a number of opportunities for residents to accept preceptorships in Iowa communities. We really think it is starting to pay off. The greater the opportunity and the more frequent the involvement, the more likely a resident is to end up practicing there. And that's really been our purpose, motivation by involvement. And repeated involvement, actually, so that the more often the resident goes out, the more likely they end up there.

In addition to preceptorships, we have started two rural model offices, at Williamsburg and Oakdale. Our residents go to the model office at Williamsburg 2½ days a week throughout the 3 years of their residency program. They are there on an extended basis and have their own practice there, minipractice, in that community throughout the period of their training programs. We also have rural teaching practices throughout the State.

The one area of the State that was not covered by a residency program within a 55-mile radius is southwest Iowa which doesn't have a community large enough to support a program. With the help and guidance of the community, the College of Medicine has established a community practice in Red Oak involving four family physicians, and we will rotate residents through that community. Hopefully this will motivate some of them to practice in that area.

Senator CLARK. That has not started yet has it?

Dr. RAKEL. Yes; it is underway. The two newest physicians started in July of this year. So it's really been underway that long.

Now, the only statement I'd like to make is that nationally, the figures of graduating physicians from family practice residencies have been very encouraging. They've been very surprising. My personal feeling is that we need well trained physicians as much in downtown San Francisco as in Iowa. What's happening is that 57 percent of graduates have located in towns of less than 30,000 population. Now in our program at the university, we have 13 graduates so far; 10 of the 13 are located in towns under 20,000.

Senator CLARK. I'm sorry. Why don't you give them to me again.

Dr. RAKEL. We have 13 graduates of the residency program at the university. Of those 13, 10 of them are practicing in towns of less than 20,000 population, 6 of them in towns of less than 10,000 so that it looks like our plan to motivate residents to practice where they are needed is working.

Now, it may be social consciousness, as well, out there working.

Senator CLARK. That would be last year's class?

Dr. RAKEL. We had 10 last year, 2 the year before, and 1 the year before that, yes.

Senator CLARK. Is that all you have? Good, I have some other questions about it. The program is just underway, and really you are only graduating people out of the residency program, what, in two of three centers at this point? Cedar Rapids, Iowa City—

Dr. RAKEL. Four. The Broadlawns program in Des Moines and Davenport.

Senator CLARK. Des Moines and Davenport. These are the four?

Dr. RAKEL. Yes.

Senator CLARK. And so the total number you have graduated so far in this program—

Dr. RAKEL. I don't have that figure, but I think I have it here. I'll find it.

Senator CLARK. All right. And the trend there though, as you see it, is definitely for these family practice people to (1) stay in Iowa and (2) to go to the small communities in Iowa; is that accurate?

Dr. RAKEL. Yes, that's correct.

Senator CLARK. Let's go on to Dr. Richard Cook. Now, you're a resident in one of these programs and you are practicing down at Williamsburg; right?

STATEMENT OF RICHARD O. COOK, JR., M.D., DEPARTMENT OF FAMILY PRACTICE, UNIVERSITY OF IOWA, IOWA CITY, IOWA

Dr. COOK. Yes; I am in my third and final year in the program. Although my affiliation is officially with the University of Iowa, some of my training is done in Williamsburg.

A lot of the things that are pertinent have been dealt with. If I approach from a different angle and talk about why the problem exists, maybe it will reinforce what we've been talking about and maybe will give us some additional insight into the solution.

When a person graduates from college and is about to enter medical school, he may have the impression of seeing himself practicing in a small community such as Mechanicsville or such as Williamsburg, but that soon changes. Most medical schools are in urban areas, New York, Chicago, St. Louis, Iowa City, even though it is smaller, is still an urban area. For 4 years the medical student is trained only by specialists. He is never trained by anyone who can deliver primary care. He is trained by endocrinologists, anesthesiologists, orthopedists. He is educated and immersed in an urban, specialized, big city environment.

Then comes time to make a decision, to decide what specialty he wants to practice.

He moves to a residency, to more training to become a specialist or a subspecialist. These programs are again in big city areas. He then goes into practice. The only place where he can use those tools again is the big city area. It would be disastrous for a specialist to deliver primary care in a rural area. He'd be ill equipped and he wouldn't be seeing enough of the type of things he is trained to do.

I think if we can take care of that vicious cycle, we can get more people doing general care.

The problem really isn't so much training people to practice rural medicine as training people to become good general doctors. This is where some of the programs enter that we have been talking about.

At the University of Iowa College of Medicine we do have a preceptorship program whereby the student has to spend several weeks in a rural area. He is exposed to a different kind of medicine. He sees what the general doctor does rather than what the specialist does.

The next step is to create family practice residencies that have been going only for about the past 5 years. In training, a general doctor can take care of most problems, whether in a rural area or urban area. Previously, we were just training specialists. That still isn't enough, because most family practice training centers are still associated with medical schools, and they are still located in urban areas. We agreed to give the residents an opportunity to see what it is like to practice in rural areas.

This is where Mechanicsville comes in. This is where Williamsburg comes in. We're not forcing the residents to go there, but we provide an opportunity for them to see what rural medicine is like.

In looking back on the residents I have known in my training program, most of them have come in with the attitude of practicing in a fairly urban area. A change has taken place while they are in residency. Many of them have settled in the smaller communities in Iowa.

The other thing I would like to reinforce is that the time has passed where every small community in Iowa can expect to have a physician, every community of 500, 1,000, 1,500 people. I think we are going to be seeing a lot of regional health care, whereby a number of doctors form a group with the appropriate modern medical facilities.

People might not think that is such a good deal for them, but in the end they will be getting much, much better health care. The problem that I see from here is how much should the Government get involved?

The Government is already involved in funding various aspects of medical school and residency, but the problem is, what type of force or financial incentive should be involved now? If you talk to most physicians who have been out in practice a number of years, most are opposed to the Government directing physicians where to practice. We, in family practice have shown that there is opportunity in rural medicine. Maybe we just need to give it time to see if there will be a redistribution of physicians.

Senator CLARK. In that regard, in other words, sort of a "carrot and a stick" approach. I just don't know the answer to that, but perhaps you do. What is the practice in the Army? Do they pay the scholarship in return for serving so much time in the Army?

Dr. COOK. I don't know the details, but you do have an opportunity to get money during medical school from the Army in return for a future commitment.

Senator CLARK. For so long—

Dr. RAKEL. Each of the Armed Forces does it.

Dr. COOK. And I think the commitment is 4 years or so.

Senator CLARK. Now, would you call that carrot or stick? You don't have to do it. You do it out of your own free will. What is your feeling about that? Suppose the Federal Government were to provide—as they do under National Health Service Corps—scholarships in return for service for 2 years in an underserved area. Do you find that offensive or not?

Dr. COOK. I personally don't find it offensive.

The reason that works at times is that some students feel that they do lack funds in financing their education. They feel it is a fair trade. However, there are other students in exactly identical situations who think they will be making enough in private practice at a later date that they don't need to do that.

Senator CLARK. Yes.

Dr. COOK. It is a matter of personality, a matter of feeling easy with that situation.

Senator CLARK. All right. Sorry to interrupt you.

Dr. COOK. That's all I have to say.

Senator CLARK. Before we have questions, let's go on and hear Jim Coulter who is a banker in Williamsburg, if I'm not mistaken. So I'm particularly interested in hearing your view of whether this may have been positive or negative as far as Williamsburg is concerned.

Maybe we can move the microphone.

STATEMENT OF R. JAMES COULTER, JR., PRESIDENT, WILLIAMSBURG COMMUNITY DEVELOPMENT CORP., WILLIAMSBURG, IOWA

Mr. COULTER. Thank you, Senator Clark.

First, Senator Clark, I am executive vice president of Security Savings Bank of Williamsburg. Second, which is one of the reasons I'm here is I am president of the Williamsburg Community Development Corp.

Let me first go into a little bit of an analysis of Williamsburg. It may sound somewhat like the Mechanicsville story, and well it should. Williamsburg is a community of about 2,000 people. It is 2 miles south of Interstate 80, approximately 25 west of Iowa City. It is an agriculturally based but not dependent community.

We have many people at work at Amana Refrigeration; at motels, restaurants, shops, filling stations along Interstate 80; in Iowa City, Cedar Rapids; as well as every local business in town. Every store around the square is full. I think one of the things that is very important when we think about it is that there are about 40 people my age or less, which is about 30, which have come back into the town of Williamsburg in business.

So in other words, I guess what I'm saying is that it is my belief today, the same as it was all the time, that Williamsburg is a town of which I am personally, and everybody that lives there, very proud of. We are very excited about the town. We thought we had everything, at least until the fall of 1972.

We had two doctors and had had two full-time doctors on a regular basis for several years. But in the fall of 1972, one doctor left town to take a practice in Michigan. And the second doctor, Dr. Miller, soon after died suddenly in November and we didn't have any medical people, facilities, or anything else in the town of Williamsburg.

This concerned everybody very seriously, and we started immediately to find a person or persons, doctors, to come in and help the town of Williamsburg. There was a tremendous effort in the community—medical faculty as our pharmacists and dentists tried to make contact through friends in medical channels; other people tried to make contacts with whomever they knew that might be able to

provide some assistance; but in the end, the answer was basically the same.

(1) No doctor wants to come to a small town where he is away from research or study; or that (2) no doctor by himself is going to come into a town and make himself available 24 hours a day. Or that (3) no doctor is going to come into a town unless you promise him the world with no ties. And so we weren't progressing very far, but we continued at it and by the spring of 1973 the town's fortunes changed.

We were very fortunate when members of the development corporation made contact with the University of Iowa and the family practice program came to Williamsburg.

They set up their clinic in the facility which had been Dr. Miller's office and stayed there for approximately 1 year. Even though none of you have seen the facility, it was much too small for anything except for a doctor of one. I think it had two examination rooms. It was much smaller than the family practice needed not only to treat people but to teach their own doctors.

So they proposed to us that the town would reconsider building a clinic in exchange, as was the case in Mechanicsville somewhat, that they provide medical care in Williamsburg. And a new clinic was built.

It was started in the spring of 1974 and finished by the fall and family practice moved in. It was one of my responsibilities during the hearing, to discuss the financing of the building.

Senator CLARK. Right.

Mr. COULTER. First thing that we all should realize is the cost of the building for the development corporation and this does not include anything that the family practice put into it. It has now run approximately \$140,000. This 44 by 56 modular building of which there are two complete examination facilities was built, and I'll explain a little later why it is so much.

Originally, the figure was a little bit less when we first started and it was financed almost 100 percent by the two local banks in town. And I don't know whether all of you are familiar with good financing and so on, but a 100-percent loan at less than going rate is a service which was provided so that we could have in the town of Williamsburg a medical facility.

There has since been excess funds provided by the development corporation out of another project and donations provided by service clubs in the town of Williamsburg to increase the facilities that are in the clinic building. As an example, part of it was for the downstairs. There is now a place where there are residents 24 hours a day available on a rotating basis and there is a place where they can stay, a small kitchen-type situation. So it is not the nicest situation, but at least it's something where someone can stay over and have facilities to stay overnight in Williamsburg.

As I pointed out, there were two examination facilities within the one clinic building. The reason this was done was it was mutually agreed between family practice and the town of Williamsburg that (1) family practice would seek a doctor 24 hours a day to live in the town of Williamsburg, either part of family practice or otherwise. I'm sure that they would prefer him to be a part of family practice. Second, the family practice would, if in case a doctor came in or otherwise who wanted to take a portion of the medical load by himself, that half the

facility could be made available to him and half the facility be kept by the family practice.

Family practice also agreed that if fortunately enough, an entire group wanted to come in that they would abandon the facility in the town of Williamsburg.

Where are we today in the town in 1976? We do not have a full-time doctor living in Williamsburg all the time. However, we do have doctor care 24 hours a day in the town of Williamsburg. In other words, there is not one doctor living in Williamsburg all the time, but there is a Dr. X today and Dr. Y tomorrow and so on, on a rotating basis so that there is someone always at the clinic 24 hours a day. And I think that is important.

In the town of Williamsburg, we do have protection by medical personnel there at all times. We are today receiving qualified treatment from a group of qualified doctors. And I believe that most of the people in the town of Williamsburg believe, and I think, that we all should consider that many smaller communities can be provided with this quality medical treatment and care; we hope and expect that this may be the answer as to how we may be able to get it. Thank you.

Senator CLARK. Thank you very much.

I think for the sake of the court reporter here, we better take a 5-minute break and then we'll come back and have further questions. I think I probably have a good 20 minutes or 30 minutes of questions, so let's just take a 5-minute break right now.

[A 5-minute recess was taken.]

Senator CLARK. The meeting will come to order.

I visited with a couple of people in the audience that have got some ideas, too, that we want to get on record, so we'll try to and we've got about 30 minutes left so we'll try to cover these questions and give people here an opportunity to speak as well.

I thought all three of you did an excellent job. I think it has been very helpful information.

Dr. RAKEL, I wanted to ask you just some basic kinds of statistical questions again. By the way, did you find the total number of graduates?

Dr. RAKEL. I had it right in front of me all the time. It is about 50 percent. So far we've had 37 graduates in the State of Iowa from Family Practice and half of them have stayed in the State to practice, haven't gone elsewhere.

Senator CLARK. Of the 37 graduates, half stayed in the State. And so that would be about 17 or 18, I guess; wouldn't it, that stayed in the State?

Dr. RAKEL. Eighteen.

Senator CLARK. And of that 18, do you have any figures as to how many would have gone to communities of less than 7,000?

Dr. RAKEL. Yes. However, I have just counted up my graduates. I have every graduate listed here. I just haven't gone through.

Senator CLARK. Well, that gives us some idea.

Now, let me say at the outset of these questions that I honestly feel that you've done a remarkable job, you and others like Dr. Aschoff; and frankly, without your leadership now and in the past and in the future, we are not apt to have family care physicians in

this State so I compliment you and commend you for the work you have done.

I think we are only beginning, but that's the direction we have to go in. The thing that I am concerned about is whether, in fact, we're going to produce enough. At least we are going in the right direction now, for the first time in 20 years from my subjective point of view. We are reversing that.

The question is, do the statistics really show that there will be enough to make a significant difference in, let's say, the remainder of this century?

Now, I noticed that some statistics I saw here indicated that one out of every three physicians in Iowa is 60 years of age or older. Are we really going to graduate enough at this rate to do more than replace those?

Dr. RAKEL. I really feel confident that we are, based on what we have underway at the present time and what our projected needs are. We are in better shape in Iowa than most States in the country. And I think that because of the number of programs we have underway, we should produce, based on our projections anyway, enough to satisfy the need in this State. There are many other States that will be in much worse shape than we are.

One of the additional factors that I want to add to what Dr. Aschoff mentioned about things that attract people to rural practice is the opportunity to teach in residency programs and because of a residency within reach of almost any community in Iowa. This offers an additional incentive for physicians to practice where they can maintain that involvement. And that's where we have been able to achieve a net gain.

We have more physicians staying in Iowa to practice than we are actually turning out ourselves because of these attractive features, so the network and the activities around the State will continue to attract.

Senator CLARK. Well, to stay with the statistics just a little longer, now we are looking at some data that is being detected by the State office of planning and programing for the State health manpower project. And although these have not all been verified yet; and therefore, we haven't really done anything other than look at them today, it indicates that even in these last 2 years, that is, the period between 1974-76, the number of primary care physicians in the State has declined in 37 of the 99 counties and that only 33 counties show an increase in the number of physicians practicing within the boundaries.

Does that indicate to you that we haven't bottomed out yet or do you feel that we are; or isn't that a good way of judging?

Dr. RAKEL. No; I feel we have. I haven't seen those statistics and I'm not sure I would believe them because our figures show that we bottomed out 2 years ago and that we are improving and increasing.

Senator CLARK. Now, your statistics would show that there are more family care physicians in the State today than there were 2 years ago.

Dr. RAKEL. That's correct.

Senator CLARK. And would it show that about the rural area?

Dr. RAKEL. We haven't analyzed it, although we are in the process of doing it.

Senator CLARK. You are hopeful that when this program is in full swing that you will be producing about 60—

Dr. RAKEL. Per year.

Senator CLARK [continuing]. Per year. And that although maybe half of those will leave the State, you assume that then more at least will come in from other States; is that an accurate statement?

Dr. RAKEL. That's correct.

Senator CLARK. Your recent history shows that you have attracted more from other States than you have lost to other States.

Dr. RAKEL. I believe it's about 50-50. I believe we have attracted about as many or a little more.

Senator CLARK. So that you have said, I think in your testimony, you think by about 1984 or 1985 that we will have about one physician, one family care physician, for every 2,500 patients.

Dr. RAKEL. That's correct.

Senator CLARK. But do you feel that a more ideal figure is about 1 to about every 1,800?

Dr. RAKEL. Eighteen hundred to two thousand.

Senator CLARK. Do you have any guesses on about when we might be able to achieve that in terms of this? Can you project out your 2,500 figure to 1,800?

Dr. RAKEL. Well, nationally we are trying to do this. The American Academy of Family Physicians nationally is trying to stimulate enough residents to satisfy the need and to produce the doctors needed. It's difficult to do that.

In fact, in the last several years, there have been more students that wish residency programs in family practice than could be accommodated. And last year 500 students that said they wanted a family practice residency did not end up in family practice; so that there is a need to stimulate more residency program development.

The Health Manpower bill is going to help us more in that regard than anything else; and I'm just grateful that that was passed.

Senator CLARK. We did add a significant amount in the authorization. Now we've got to get the Appropriation Committee to appropriate the funds.

Dr. RAKEL. I wish you luck. We're all behind you.

Senator CLARK. All right. Then you are rather positive about it. You feel that in some future time in the next 10 or 12 years that we are going to have an adequate number of general practice—I should say family care physicians.

Dr. RAKEL. Family physicians, general practice, same type of thing. Yes; I do expect that it is going to take time because they are changing slowly.

Now when you use the term "primary physician" I assume that you are using the definition which I agree with in the Health Manpower bill which is family physician, general internist, or general pediatrician. So long as we have the other two to help out, I think we can answer the need.

It's going to be a while before we have enough family physicians. The statistics, I think, will have them faster than the county, certainly.

Senator CLARK. You think it might be the year 2000?

Dr. RAKEL. Yes; that's the year everyone is aiming for, to the year-2000.

Senator CLARK. What about the idea of physician's assistants or nurse practitioners?

Dr. RAKEL. Well, my views differ depending on where you are in the United States. We have a model practice in Muscatine using physician's assistants and we rotate residents through it. They have no choice. They must rotate through this unit so that they gain experience in working with physician's assistants in practice. In this manner they develop an appreciation—or lack thereof—for that type of situation, so that they know whether or not to use physician assistants when they get out in practice.

The Red Oak Clinic has nurse practitioners working in satellites. What we found out in Muscatine is the physician's assistant can be a very valuable person and can contribute to better quality health care. But the doctors there insist that this can occur only if their physician's assistants work in the office with a physician. They are opposed to the satellite operated clinics.

And in Iowa, where we really have access to good health care (even now with some of our citizens 30 minutes away from a health care center), the need for isolated allied health personnel is less severe than it is in Nevada or the truly isolated rural States. And there, certainly, a physician's assistant or nurse practitioner practicing in isolation is better than no care at all. I would certainly support it in those States.

In our State here, we support them working together with a physician.

Senator CLARK. I had never heard that figure before. All of our citizens are within about 30 minutes of their physicians?

Dr. RAKEL. Well, the word "all" is a strong one, but pretty close. Senator CLARK. Almost all?

Dr. RAKEL. Yes; within 30 minutes. I've been a big city boy all my life until now; and there were few people in the big city who were closer than 30 minutes away from their doctor, with the traffic problems.

Senator CLARK. Now, what do you see, Dr. Rakel, what do you conceive as an appropriate Federal role, a Federal Government role, for the Government to play in providing general health services?

Dr. RAKEL. Much of this has already been done and it needs to be maintained. Without the impetus of Federal funding for medical schools, they would never have developed departments of family practice. And we have to increase our involvement and exposure in the medical schools to continue to attract students to enter the field.

We can do all we want in the postgraduate area and it's going to be worthless if we don't motivate the students to enter the field. So, the continued funding incentive is crucial.

In addition, everybody expects some direction, some control, over future practice locations, in spite of their preference for the free enterprise system. It just has not worked out.

I think the National Health Service Corps is an excellent solution. The only problem with this group in the past was that they were attracting residents into the National Health Service Corps before they finished their residency. And, obviously, when their 2 years were up, they tended to return to a residency for further training.

I think they can be a lot more effective in recruiting physicians to these areas to practice.

Senator CLARK. Good, thank you very much.

Dr. Cook, what influenced you to become involved in family practice?

Dr. COOK. What really helped was that I was exposed to some primary care opportunities in medical school. Then my attention was directed to looking toward family practice residencies. If I hadn't had several specific notations, I wouldn't have ended up in family practice. I would be another type of specialist, a nonprimary care specialist at this time.

Senator CLARK. So being exposed to it was the crucial thing as far as you are concerned?

Dr. COOK. Yes. People are going to be reluctant to sign up for a career opportunity which they haven't been exposed to at all; and in many cases, are unaware of.

Senator CLARK. You think you will practice in a smaller community?

Dr. COOK. I haven't made that decision yet. I haven't ruled it out. I don't have any negative feelings toward practice in a small community, but it would have to probably be with a group of physicians, and it would have to have the necessary medical facilities. Probably a hospital should be nearby, and we should have adequate laboratory things at hand.

Senator CLARK. You just don't think you would be comfortable with or could provide the quality health care without those facilities; is that what you are saying?

Dr. COOK. If I had to practice alone in a rural community, I could do it. The services I would provide wouldn't be as good, and I wouldn't like it as much. I don't think I'd voluntarily choose doing that. I could do it, though.

Senator CLARK. I was wondering, Mr. Coulter, what do the people in Williamsburg think about this? I mean, these doctors are rotating pretty quickly. A lot of people like to have the same doctor all their lives or for 10 years at a time, as long as they can have them and so forth. What do they think of that? Have they adjusted to that pretty well?

Mr. COULTER. That is a difficult question to say have they adjusted to it or not.

Senator CLARK. Each one of them are different, I suppose.

Mr. COULTER. That's true. That is one of the primary problems we have in the town of Williamsburg. People have been used to their own private individual doctor who, in their minds at least, would provide them care whenever they asked for it in whatever means they asked for it. I don't always think that is true; but that is what is in many peoples' minds. The family practice, even though it's there 24 hours a day as you pointed out and we all well know, it is an individual with a different doctor.

Many people object to that. They think they are not getting the kind of care they need. I think what we are saying, however, and I think a couple things have been done to help this by family practice, I think that we are seeing this attitude change. I think family practice has helped because where they may provide a number of doctors, they've tried to have maybe three or four doctors work with potentially a group of patients so that maybe one doctor is not there when you need

him on an emergency—and I should go back. If there is a non-emergency, you can always ask for a doctor and have him to treat you. You may not be able to get him today but tomorrow for routine situations. For an emergency what they have tried to do is have three or four doctors familiar with a particular person's case who potentially have met that person so that he can feel a little more at ease.

I think that we are getting quite a bit of good feedback in terms that there is much more acceptance of family practice.

And if I could add one more thing. I think a very primary consideration toward acceptance of family practice is their tremendous medical care. They are now seeing, as was pointed out in Mechanicsville, diagnosis in situations where people who were either potentially sick or really sick that might not or wouldn't have been picked up by some of the treatment in the very exhaustive way that they go about their type of treatment.

I think the expression was used before and I don't know whether it is fair to use it, but it's not a seat-of-the-pants type approach. That's definitely not what we have and I think people appreciate it because before it was inconvenient to make out a complete family history. That took 30 minutes. They didn't have the time. Now, they fully accept why those things are being done.

Senator CLARK. Do many people in Williamsburg say, "I don't want to do that. I want to go find a permanent doctor." And they drive off some place else?

Mr. COULTER. We have had persons that have left. And I think the major amount of these people that are not being treated by the family practice in Williamsburg left between the interim between the fall of 1972 and when the family practice was started and now are scared to come back. As opposed to, I think, there are very few people who have been treated by family practice who now have left the potentiality of being treated by family practice and found their own doctor.

I think it's people who have gone during the interim and now don't want to come back.

Senator CLARK. You think on the whole now as far as you are concerned, that Williamsburg is served a lot more adequately than it was before, in terms of having emergency care, diagnostic facilities, or potential?

Mr. COULTER. Well, let me answer it this way. I would not want to say that it is better or worse. There are pluses and minuses to both kinds of care. I do believe, however, that there is much more accurate diagnosis under this system than prior.

Again, when you go back, maybe the way it was before and the way it is now comes up with the same answer. If it does not. I would be much more happy to have it under the way it is now than to take the situation as it was before.

Senator CLARK. All right.

I think we are going to see if there are any comments. I know there are some comments from the floor. Incidentally, I've got several addressed envelopes here that anybody can fill out to make any statements you would like as a witness and mail that to me within a week and it will be put in the record here as if given. I don't want to close anybody out. Anyone here is welcome to do that. Take as many sheets as you like.

Let's take just another 5 or 10 minutes to take any brief statements that anybody has to say about anything you have heard here. I'd like to try to limit it to a couple of minutes so that we can get as many of these in as possible.

**STATEMENT OF LES HENDELES, M.D., COLLEGE OF PHARMACY,
UNIVERSITY OF IOWA, IOWA CITY, IOWA**

Dr. HENDELES. Senator Clark, I am Les Hendeles, a resident of Iowa since 1972 and assistant professor of clinical pharmacy at the University of Iowa.

Our State is considered by some to be leading the Nation in the use of the clinical pharmacist in rural health care delivery. I am here to familiarize you with this development and urge its continuation and expanded financial support. I believe that the quality of patient care is enhanced when the services of a clinical pharmacist are included in the rural health care delivery system.

The role of the clinical pharmacist focuses on the application of drug knowledge to patient care. This individual acts as a consultant to the physician to help insure that the choice of drug therapy is the most efficacious, least toxic, and the least expensive regimen available. Practicing with the physician in the same physical location, as is done here in Mechanicsville, in the family practice offices in Williamsburg and Oakdale, and at other facilities in Iowa, the clinical pharmacist also takes responsibility for educating patients about their medications.

Studies are in progress in Iowa to document the extent to which the clinical pharmacist enhances the quality of drug prescribing and prevents drug interactions and adverse drug reactions. For example, here in Mechanicsville, it is believed that some asthma patients have less frequent or less severe attacks as a result of the use of pharmacokinetics which was introduced by the clinical pharmacist.

We individualize theophylline dosage regimen in selected patients by measuring the amount of drug in the blood and making subsequent adjustments in dose which provide maximum benefit with reduced toxicity. Several Iowa physicians in other rural areas have similarly mailed theophylline blood samples to the College of Pharmacy in Iowa City where the results, interpretations, and recommendations were phoned to the physician. It is felt that these services have led to less frequent emergency room visits or fewer costly hospitalizations for many asthmatics.

Another example encompasses geriatric patients in the Mechanicsville Nursing Home who have received special attention. Because of the large number of drugs that older patients often must take, the clinical pharmacist monitors them daily to alert the physician to potential drug interactions and adverse effects. It is believed that the interface of the clinical pharmacist between nursing home and physician reduces the cost of medication and saves physician time that can be spent seeing additional patients.

These activities and the accrued benefits are only possible when the clinical pharmacist is practicing in the same physical location with the physician. Direct access to pertinent medical information in the patients' records necessary for evaluation of therapy, close contact

with the physician for feedback, and dialog which continues throughout the day are prerequisites to the best use of the clinical pharmacist.

In summary, we feel that these initial models have demonstrated that the clinical pharmacist makes a strong contribution toward improving the quality of patient care. With legislative financial support, these services can be provided to all rural patients.

Senator CLARK. Fine. Thank you. May we have your statement.

Let's go on. Try to limit the statements to about 2 minutes. Identify yourself.

**STATEMENT OF JEFFREY A. WEIH, PHYSICIAN'S ASSISTANT,
IOWA CITY, IOWA**

Mr. WEIH. My name is Jeff Weih, a physician's assistant from Iowa City. My statements are based largely upon the things I quoted panel members saying today and my feelings about what they said.

Basically, I want to propose a new approach to health care education based upon the apprenticeship of anyone who has a desire to learn to be a health worker to any practicing health worker.

For example, someone in this town, perhaps a high school student, perhaps a person 50 years old, could, if the arrangement was satisfactory to both parties involved, set up an apprenticeship arrangement with a general practitioner, or an incoming medical student go directly to such a general practitioner. This would increase the sense of community because the person could be coming from this community. It would increase its sense of identification with this area and increase the exposure to general practice and increase the motivation by involvement because there would be involvement.

This would increase training by general practitioners and not specialists because it would not be a specialist doing the training. It would decrease the cost of the system as it now stands because although it's true that people can drive to a place 40 or 50 miles away, that may not be true in 5 or 10 years.

Medical education should begin with the patient and turn to the textbook only because of the patient's problem. Textbooks should not come first. This type of system, this apprenticeship approach, would avoid discontinuity in personnel. That is, the apprentice would always be there. You wouldn't have one person coming in for 2 months and leaving and another person coming in. I know patients don't like this.

It would avoid overtraining. It would be easier to finance because the health worker would already be living in the place where he or she was working. It would avoid "forcing people into places they don't want to go." It would decrease pipelining of people through schools. It would be made possible by increased availability of communication and information.

Tests could be developed to guarantee competency of an apprentice. And I guess I just want to add that if anybody knows of any physician that needs a PA, I'm looking for a new job.

Senator CLARK. Well, we do a little referral work once in a while. Anyone else? Yes.

STATEMENT OF DAVE LOXTERKAMP, IOWA CITY, IOWA

Mr. LOXTERKAMP. My name is Dave Loxterkamp and I'm a medical student from Iowa.

Senator CLARK. You're a medical student at the university?

Mr. LOXTERKAMP. Right. We've heard some testimony to the effect that the exposure during medical training tends to influence not only what people practice—for example, the tendency to become specialists—but also how they prefer to practice—for example, the tendency to settle where there is a group of other physicians, where there is sophisticated medical equipment to make diagnoses, where they can be assured of continuing medical education, where they and their spouse can have an essential economic and social climate to feel comfortable with, and such.

I would like to say that I hope to practice in a rural area some day. I do not look toward a large group practice, but rather look toward working with maybe a group of 2 or 3 people in a town around the size of 3,000 maybe to 5,000.

Senator CLARK. Two or three other physicians?

Mr. LOXTERKAMP. Right. But also, I'd like to practice with dietitians and public health nurses and clinical pharmacists, nurse practitioners and physician's assistants, and other kinds of people like this.

And I would like to advise—or stress, or inform—medical educators that I see a need to learn more about how to practice this kind of medicine in rural America during my medical education, during my 4 years of medical school.

Once again, towards less sophistication, towards home health care delivery, towards working with teams of professionals, learning how to develop a health education project in the community and that sort of thing. And I think that probably some of this is done in residency training, but I think again the exposure during medical school really helps to reinforce your value system and I would urge that health educators look towards developing kinds of learning experiences that involve these kinds of approaches and philosophies.

Senator CLARK. Sounds very interesting. In other words, to consider very carefully as a part of the educational process the work with public health nurses, nurse practitioners, and homemaker health care providers.

Mr. LOXTERKAMP. Right.

Senator CLARK. Interesting. Yes.

**STATEMENT OF JAMES A. DUBBELS, R. PH., CLINIC PHARMACY,
OSCEOLA, IOWA**

Mr. DUBBELS. I want to ask you a question as well as make a statement. My name is Jim Dubbels and I'm a registered pharmacist from Osceola.

What we really need in Osceola—we have a good clinic and a hospital and everything, but we don't have a general surgeon. The comment I'd like to make is that even though the University of Iowa now tries to put out more family practice residents and more family practitioners, I think there's also a real need for a general surgeon. We

have a 50-bed hospital that has a surgical wing, and everything provided, standing empty.

The surgeon we did have was killed 3 years ago. And there is no way on earth I can ever foresee us getting another one in the realistic future. Perhaps aiming the education into a general surgeon specialty as well as a family practice specialty to put them in a rural community to make use of a \$45-a-day bed instead of a \$90-a-day bed in Des Moines where we refer everybody.

So perhaps this is something the educators can look forward to. A medical student can still specialize in surgery or something like that but not in a "specialty area" of surgery. Many of these minor surgical techniques could be done locally to save dollars both to private patients and title 19 or social security covered patients.

Senator CLARK. Let's see if we've got any reaction here from Dr. Rakel or Dr. Cook. Do you have any general thoughts about that?

Dr. RAKEL. Yes, I do. Too many surgeons already feel like they've overproduced. It is true, they're not out into all of the rural areas, but there were many surgeons in practice where I practiced who had a hard time making a living. So I felt the figures were probably accurate and we already have produced quite a few. I would guess that deficit will not last very long, because the production hasn't dropped off that much. I would expect they are going to be more available to the rural areas.

The other point, though, is that we do offer a fourth year of training in the residency to train family physicians in the technical skills of doing surgery. This is a full year of doing nothing but surgery for those that wish to do exactly what I referred to.

Senator CLARK. Is there any inclination for them to take a fourth year? Have you had any takers?

Dr. RAKEL. No. We have one resident now who says he is going to take it. Most of the residents are not interested in doing surgery.

Mr. DUBBELS. Previously, our surgeon did most of his surgery 1 day of the week or morning, and he was in the group practice as a general practitioner the rest of the week. Of course, he was a 45-year-old physician who grew up this way in Missouri and his father had had the same type of practice. He really enjoyed the general practice. Maybe you don't find that kind of person anymore in medical school.

Dr. COOK. Two quick comments to help answer that.

First of all, the surgeons are not enthusiastic about teaching family practitioners any of the aspects and technicalities about the surgery because their field is already overcrowded. And for us to do surgery takes some of their business away and that is a real point here.

Second, if you were to even do minor surgical procedures when you are out in practice, your malpractice premium automatically goes up from \$1,000, \$2,000, or \$3,000 a year to the range of \$10,000 a year. So you'd have to do quite a bit of surgery. If you are only planning on doing a few procedures a week, you might not even pay for your malpractice premiums.

Senator CLARK. Why is it if we have so many surgeons that we can't get some out to the Osceolas?

Dr. COOK. It goes back to medical school and residency. Again, they are trained in big city urban areas and feel that to practice and make a living they need to go to big city urban areas.

I don't have any definite statistics to quote, but there have been studies showing that there are too many general surgeons, that their distribution is toward urban areas. There is not enough surgery there to give all of them a full practice, so they end up doing primary basic family care, something which they are not trained to do.

Senator CLARK. Interesting. What other fields and practice, Dr. Rakel, could address this? What other fields do we really have purportedly too many specialists in?

Dr. RAKEL. Most of them are the surgical specialties and some of the internal medicine subspecialties—although most of them are surgery oriented.

Senator CLARK. Anyone else?

STATEMENT OF EDWARD LAMMER, IOWA CITY, IOWA

Mr. LAMMER. My name is Ed Lammer. I'm also a medical student and I just want to emphasize again that I think that the solution to these problems lie in medical education itself and actually exposing the students to a family practice. Because like Dr. Rakel said, when they started out, 50 percent of the class are interested in some kind of family medicine or primary care. But we're in Iowa City, we're being taught at a center that has all these facilities that you just don't have around the rest of the State and you see patients being referred from all over the State for illness that doesn't exist in other places. So I believe the training and the types of role models and professionals that you see are not leading you to get interested in family medicine.

Senator CLARK. It sounds like many of the things they are doing in the residencies, family care residencies, and so forth, at least is a beginning in that direction; do you agree?

Mr. LAMMER. I'm talking about medical school itself.

Senator CLARK. Oh, you're talking about medical school itself. Anyone else.

STATEMENT OF MARGERY NORTON, R.N., CEDAR COUNTY PUBLIC HEALTH NURSING SERVICE, TIPTON, IOWA

Ms. NORTON. Yes, Senator Clark, I would just like—Marge Norton, Cedar County Public Health—I would just like to make the statement that I feel that public health nurses play a great role in helping the physician in his work, also the family.

We are out into the community. We are at the basic grassroots. We are into the home. We not only give direct nursing care, we help supervise health maintenance. We must gear our thinking towards preventive medicine as well as treating the acute and it starts in the home.

We need more public health nurses and we need more funds for this. And I think if you would speak with doctors—I was pleased to hear this young gentleman say he would like to be exposed to the other services. We do give a service. We are seeing older people. The population is growing older, you know, and——

Senator CLARK. That's right.

Ms. NORTON. And we are seeing more elderly people. Is it not more economical to maintain an individual in their own home than to say put them in a nursing home at the county's expense or it takes all of

their money in a nursing home. We try and maintain them as long as we can in the home.

Senator CLARK. Well, that's very well stated. I think it's a good note. We're looking presently at physicians and physician's assistants, but certainly we don't want to neglect all of the other rural health care services that are provided, including public health services.

Dr. RAKEL. Senator, could I second her comment? One of the problems with health care delivery now is the fragmentation of the bureaucratic system, which puts the public health nurses in a separate agency. Agencies are not communicating adequately; and England is way ahead of us since they put all of the officials together in one center.

As we go to group practices, as opposed to the isolated solo physician, and put a group of physicians together than we can hope to do that.

Senator CLARK. Well, our 5 o'clock time has come and I'll have to stop at this point. But remember, if you have anything to add or to say, we do have these forms so that you can fill them out. They will be printed as if presented here. And they are on the table in the back of the room along with other literature.

We thank you very much for coming. This hearing is adjourned.

[Whereupon at 5 p.m., the subcommittee recessed, to reconvene at 11:30 a.m., October 19, 1976, in Turner Hall, Eldridge, Iowa.]

RURAL HEALTH SERVICES IN IOWA

TUESDAY, OCTOBER 19, 1976

U.S. SENATE,
SUBCOMMITTEE ON RURAL DEVELOPMENT
OF THE COMMITTEE ON AGRICULTURE AND FORESTRY,
Eldridge, Iowa.

The subcommittee met, pursuant to notice, at 11:30 a.m. in Turner Hall, Hon. Dick Clark (chairman of the subcommittee) presiding.
Present: Senator Clark.

STATEMENT OF HON. DICK CLARK, A U.S. SENATOR FROM IOWA— Resumed

Senator CLARK. The hearing will come to order.

I want to welcome you to this hearing which is a hearing of the U.S. Senate Subcommittee on Rural Development of the Senate Committee on Agriculture and Forestry. Our purpose in being in Eldridge is to complete a series of six hearings that we have held in various parts of the State.

We held hearings in central Iowa near Des Moines in a community of Grimes and then toured a facility in Madrid where a physician's assistant, a full-time physician's assistant, is on duty. We then held hearings out in Moville which is a small community just east of Sioux City. And we held hearings in Treynor, which is a small community just east of Council Bluffs, and toured the Malvern satellite clinic that is connected with the Red Oak group practice.

We also looked yesterday at a group practice that is taking place as a result of a National Health Service Corps in Traer and then yesterday afternoon over in Mechanicsville, southeast of Cedar Rapids, where we saw the satellite clinic out in Mechanicsville that is being manned by the physicians out of the residency program in Saint Lukes and Mount Mercy in Cedar Rapids.

In other words, this is the sixth of six hearings in which we are really looking at health care problems in rural areas in Iowa. Frankly, we have also looked at similar problems in New England. We are going to be looking at similar kinds of problems in Appalachia and in the South this next year.

So our subcommittee is interested in trying to get a view of what are the unique problems of bringing adequate health service to the smallest communities. We are particularly interested in communities of 10,000 or less. And of course, in this series of hearings we are looking most particularly at the problems in Iowa.

Now, we found there are some rather interesting things. First of all, we found that there is a disturbing maldistribution of family care

physicians. We are speaking of family care physicians because these are the people who come to rural areas. These are the people who we need in rural areas.

We can't have a whole bevy of specialists in every small community, obviously. And it has become increasingly apparent that we cannot expect that each one of the 952 communities in this State are going to attract a physician for reasons that we are going to be talking about and asking about here in the hearings today. But we, in just a general way—and by the way, county lines and city lines are meaningless in analyzing doctor distribution but it is one way, at least.

We know right now that one-half of all the general practitioners, all family care physicians, in this State are located in just 6 counties—6 of the 99 counties. The other half are located in the other 93 counties.

Now, as I say, it is dangerous to conclude from that that everybody ought to have an equal distribution by county. That would not be wise at all, but it does show you the very heavy concentration of family care physicians and that's the problem.

We've got, I guess, in Iowa about 1 family care physician for every 2,500 people and in many places the ratio is much greater than that. If you look at the map at the back of my head here, for example, you will see that we have colored in the counties that have lost physicians in the last 2 years alone. There are 37 counties in Iowa that have lost family care physicians. That is, they have fewer now than they had 2 years ago. And if you look at them carefully, you will see with some exceptions, that most all of them are the most rural counties in the State. And you see that in some counties like Adair County, just west of Des Moines, that we have 1 family care physician for about 9,000 patients. We must remember, however, that we are looking at a county line which is not, perhaps, the most accurate way to look at it, although we don't know of any other way to look at it.

But in that particular county, for example, there is one main center, Greenfield, and there are no other easily accessible centers for people in that county to go to outside the county. They would have to go all the way over to another county which has a rather similar situation. So it's a fairly accurate representation, I think.

So we have got some problems. And everyone acknowledges that the question is not whether we have a maldistribution of problems so much, but rather what can we do about them. And we think we have got some interesting things that are happening in this part of the State in terms of what local health personnel are doing about it.

We came down here this morning from De Witt where we looked at a very attractive clinic there that has been constructed by the hospital association. They have got the nursing home, the hospital and the clinic but have had great difficulty in getting adequate physicians there. They do have a physician, Dr. Marme, who has lived there for several years. He practices also in Clinton, and works there each morning in the clinic.

Now, through the family residency program in Davenport they have been able to attract another full-time physician who works there in his residency for a 3-month period. We are going to be hearing about that program in the second panel—we will have two panels today—when Dr. Smith, who is director of that family practice residency program in Davenport, will be our first witness in the second panel. We are also going to hear from Earl Banks, who is the hospital

administrator and who helped construct this clinic; and the mayor of De Witt, Dick Mohr. Then our first panel which is directed at that problem of health care in rural areas in a slightly different way is going to talk to us about the group practice in Maquoketa and how they have established a satellite clinic out in Wheatland staffed by a nurse practitioner, Joan Wentworth, and a doctor from Maquoketa, Paul Koob. And then Bob Stankee will speak. He's a Wheatland businessman who has been very active in the community in trying to get health care there and I think in a pretty good position to say how well that program has worked.

Now, we are looking at these programs not just in the sense of Maquoketa and Wheatland or not just in De Witt or Davenport, but this committee hopes to get some ideas from these programs that we can talk about to the rest of the country which may provide a basis, a pilot, a model which other parts of the country can look at and hopefully learn something from.

And then, finally, we hope that we come up with some ideas out of these hearings about what the Federal Government ought to be doing, if anything, to try to improve the situation. Do we need more money for training doctors, for example, in family care residencies? Should we be putting more money into hospital programs like the ones that Dr. Smith directs to get more family practice physicians so that we can have some people in the De Witts and Maquoketas and Wheatlands? That's one question.

Should we be reimbursing under medicare to physician's assistants, nurse practitioners like Joan Wentworth? Is that a part of the answer in terms of getting better care out here? Should we be loaning long-term, low-interest money to small communities to be able to build or construct or reconstruct family care clinics? These are the kinds of legislative and administrative questions, that we are interested in at the Federal level.

That is basically what I wanted to say by way of introduction and now we are going to go ahead and hear the first panel. I think we have asked each of the panelists to spend about 5 minutes or so talking about their experience, their feelings about rural health care and then we are going to have probably half an hour of questions. Then we will go to the second panel and then at the end hopefully there will be some time for people in the audience to make a comment of their own on what they think about all this. Then, I think we will break up the hearing at 2 o'clock.

So let's go right ahead, Dr. Koob. You are the physician at the Maquoketa Clinic. And as I've said, you provide care, I think, in fact not just to Wheatland but also in the small community of Wyoming. Do you want to tell us about that, Dr. Koob?

STATEMENT OF PAUL H. KOOB, M.D., MEDICAL ASSOCIATES OF MAQUOKETA, MAQUOKETA, IOWA

Dr. KOOB. Medical Associates of Maquoketa was first established in 1970 as a solo practice. Shortly thereafter with its continued growth a physician was added and then two and it has continued to grow since.

Its main objective was to provide primary care for the people of Maquoketa and the surrounding areas. In recent years we realized

a crisis has developed in the rural communities of Iowa with small communities unable to find adequate physician help. We realized that problem and in January 1973 we established our first satellite clinic in Wyoming, Iowa. That has been in operation with full-time physician coverage 5 days a week since January 1973.

A regional Iowa medical program did a study for us in 1974 to establish the feasibility of another satellite. They looked at several communities in eastern Iowa that did not have physicians at that time and were in need of them. They didn't look at anybody that had a physician so there were several communities with older physicians that weren't covered.

Out of that study it was deemed that Wheatland would be the best potential for a second satellite and in September 1975 we opened the second satellite in Wheatland. Both clinics are staffed by our physicians, and the Wheatland Clinic alternates between myself and Joan Wentworth, a family nurse practitioner.

The Associates intend to continue the policy of providing primary health care for the people of Maquoketa and at the same time establishing primary health care centers to serve medical needs in the surrounding smaller communities.

In Maquoketa we run office hours from 9 until 5. Wyoming is 9 to 5, and Wheatland is also 9 to 5. Wyoming and Wheatland are closed on Saturday but Maquoketa is open Saturday mornings.

We also have worked out of the Jackson County Public Hospital emergency room where there is a physician from our group on call 7 days a week, 24 hours a day and there are reporting systems at all three satellites so that any calls they have, a phone number is available where they can reach us at any time.

We work down on an appointment schedule for three of our physicians. One is a semiretired physician who wanted to cut down. Another is our general surgeon. And we also have a pediatrician who is currently on leave but she worked on the appointment basis, too. The rest of the physicians work on a first-come, first-served basis at our satellites and we feel this is in keeping with primary health care. When they need the help, we are available.

We also stay open during the noon hour to help any patients during that time. We are available at all times at least by phone whether the clinics are open or not. And the clinics communicate among themselves quite well.

We have a record system that is available to both the Maquoketa office and the Wheatland office and Wyoming so that the patient can be seen 1 day and the next day whatever records have been done at that clinic will be available in the Maquoketa office the next day. We do this by a dictating system. It has worked out quite well for us and we hope as the opportunity presents, to continue expanding and improving health care to the small areas.

A big portion of our time is spent in the rural areas. We also have a problem in doctor recruiting; and therefore, we established the nurse practitioner in Wheatland and she is very vital to us in taking some of the everyday chores off of us and helping with direct primary health care.

So I think it would be well to hear from her now.

Senator CLARK. Yes. Good. That's a good start. Let's move the microphone over a little here so that we can hear her.

Now we are going to hear from Joan Wentworth who is a family nurse practitioner at the Wheatland Clinic and I guess at the Wyoming Clinic; is that true? Oh, just at Wheatland.

**STATEMENT OF JOAN WENTWORTH, F.N.P., MEDICAL ASSOCIATES
OF MAQUOKETA, MAQUOKETA, IOWA**

Ms. WENTWORTH. And Maquoketa.

Senator CLARK. All right.

Ms. WENTWORTH. I'm a family nurse practitioner. That is probably a new term for you and the reason for that is that it is something new in medicine. In fact, there are only six family nurse practitioners in the State of Iowa. And I am the only one in eastern Iowa.

The fact that somebody else can take care of you when you are sick is a new concept and it takes some getting used to. But my program was created because we do have a doctor shortage. Doctors often go into group practices or into specialties and that necessitates that they live in larger cities. And this leaves small communities in rural areas without any doctor and these people have to travel a long way to get any medical care no matter how minor.

My job, if I work with a physician in a clinic, is to see routine things to take care of the routine, everyday things—routine blood pressure checks, routine physicals and checkups and also minor illnesses such as sore throats, colds and influenza. And by my taking the load of these patients off the doctor, it leaves him more time and more energy to take care of the patients who are acutely ill and in his level of skill and competence.

I can also help the physician by helping him to extend his services into the rural areas without overextending himself and I can do this by staffing or partly staffing a satellite clinic. Even though I am away from him in the home office, I am still under his direction and supervision and I'm also in constant telephone contact with him for any advice or consultation that I need in caring for patients.

I am not a doctor but I am more than a nurse. A nurse practitioner was created to fill a need and that was getting more health care and better health care into rural areas. And I think a nurse practitioner fills that need very well.

Senator CLARK. Excellent. I have several questions I want to ask you about that because I think that the nurse practitioner, from the testimony I have heard this last week, can do—I think, at least that's what we want to examine—can be an extender of health into the rural areas just as you said in your last sentence.

Well, we are going to hear now from Bob Stankee who is a Wheatland businessman. I'm very much interested in this whole problem and how it has affected Wheatland, in particular. So we will hear from you next.

STATEMENT OF ROBERT R. STANKEE, WHEATLAND, IOWA

Mr. STANKEE. Well, I think we are very fortunate to have a satellite clinic in Wheatland. Wheatland, like many of the other small towns, has been without a doctor for many years, ever since Dr. Riedsal passed away. And ever since that time I have worked on the doctor

committee with the Wheatland Businessmen Association to try to get someone to come in and practice in Wheatland.

Well, you know about how hard that is. It is a hard, hard job. There aren't very many doctors who want to come into a small town and expose themselves to working 18, 24 hours a day. So anyway, we were unsuccessful like all the other towns under 1,000 people.

And then when the Iowa regional medical program came along and conducted that survey of 2 years ago, I think that was our biggest break. They decided that Wheatland would be the most likely place for a satellite clinic. So our Medical Associates from Maquoketa opened up the satellite clinic about a year ago and they have done an excellent job of serving the people of our community since that time.

I know that there have been some emergencies that have come up which we were very, very thankful they were there. I think they have saved some lives.

Of course, it is a long, slow process, you know, to develop a practice. I don't know who it might be or where, but everybody in our community has been going to another doctor in another town for several years. But the practice at the medical clinic there is gradually improving and people are getting accustomed to it.

As far as I am concerned, the satellite clinic concept for medical service in the rural areas is the best way to go. I certainly appreciate all the efforts that Senator Clark and some of the others have done to promote this idea.

Senator CLARK. Good. Let me start the questioning with you. Do you go by the name of Bob or Robert?

Mr. STANKEE. Yes, Bob.

Senator CLARK. Bob, yes. You mentioned that you had a physician until about when?

Mr. STANKEE. In 1969 I believe it was.

Senator CLARK. About 1969. I'm trying to think of Wheatland. It's about 1,000; isn't it?

Mr. STANKEE. About 900, yes.

Senator CLARK. About 900. And you had always had a physician until 15 years ago?

Mr. STANKEE. Yes, we always had our own physician in town until Dr. Riedsal died and then, of course, we became like all the rest of small towns and we wrote a lot of letters, we got correspondence from Iowa Medical Society and followed up on doctors who were thinking about moving or new doctors going to graduate or ready to go into practice. Well, we followed them up. It was pretty tough. They aren't interested.

Senator CLARK. So you really went out to look. You searched for what—15 years?

Mr. STANKEE. No, 1969.

Senator CLARK. I'm sorry. I thought you said 1960. So about for 6 years or 7 years or something like that?

Mr. STANKEE. About that.

Senator CLARK. And what did they say? Why didn't they want to come?

Mr. STANKEE. The other doctors?

Senator CLARK. Yes.

Mr. STANKEE. You know, Senator Clark, we hardly ever got an answer.

Senator CLARK. I see, I see.

Mr. STANKEE. Oh, of course, we talked to a few of them. They were interested more in—well, they wanted to specialize. But even if they were in family practice, they were more interested in being in a larger city with a hospital facility and everything.

Senator CLARK. No hospital in Wheatland, is there?

Mr. STANKEE. We have a nursing home there.

Senator CLARK. How many bed nursing home?

Mr. STANKEE. Fifty.

Senator CLARK. Fifty-bed nursing home. About like the one in De Witt, about the same size?

Mr. STANKEE. Yes.

Senator CLARK. Well now, how does the community react to this availability of the doctor and nurse practitioner on a—I guess you would say on a somewhat part-time basis?

Mr. STANKEE. Of course, that's a question, you know, that is in everybody's mind. We kind of sit back and look a little bit, you know, and watch and see if it is going to succeed. Of course, that's a bad attitude. See if they do enough that it could succeed; right?

Senator CLARK. Yes.

Mr. STANKEE. So it is gradually taking hold and we are getting more traffic all the time.

Senator CLARK. When did this start?

Mr. STANKEE. A year ago. About a year ago; wasn't it, Paul?

Dr. KOOB. Yes.

Senator CLARK. And you think the community increasingly is now accepting that idea?

Mr. STANKEE. Oh, yes.

Senator CLARK. So you feel you have significantly better health care now in that community than you had?

Mr. STANKEE. Very much so, yes.

Senator CLARK. What happens if there is an accident? Do you have ambulance service?

Mr. STANKEE. No, we don't, but that is one thing that is next on our list.

Senator CLARK. Where would you call an ambulance from?

Mr. STANKEE. Well, De Witt or Oxford Junction.

Senator CLARK. Oxford Junction?

Mr. STANKEE. Yes. Of course, they give us very good service; but still 15, 20 minutes can make a lot of difference.

Senator CLARK. Well now, let me come back to, I think, Dr. Koob for a moment and then some questions of Joan Wentworth.

Dr. Koob, how big is Wyoming; do any of you know?

Dr. KOOB. I don't know.

Senator CLARK. I've been there a dozen times. I think it must be about 800.

Dr. KOOB. About 800, yes.

Senator CLARK. OK 800. And you established that clinic first?

Dr. KOOB. Right.

Senator CLARK. When was that established?

Dr. KOOB. January in 1973.

Senator CLARK. So you have been operating there almost 4 years?

Dr. KOOB. Yes.

Senator CLARK. And what is the population of Maquoketa now?

Dr. KOOB. Just around 6,000.

Senator CLARK. Just around 6,000. I just want to kind of get a picture now. There are how many of you in practice in Maquoketa?

Dr. KOOB. There are six in our group.

Senator CLARK. In that group of a community of 6,000.

Dr. KOOB. Yes.

Senator CLARK. And give me again the number of family care physicians out of that six.

Dr. KOOB. About five.

Senator CLARK. Five, and the other is a pediatrician?

Dr. KOOB. A pediatrician who is on leave and general surgeon right now there is six. With the pediatrician there is seven.

Senator CLARK. Seven, two of whom might be considered specialists and five of whom are family care. For a community of that size I can't remember thinking of that many.

Dr. KOOB. That is just our office. Now, there is also another office with physicians, too.

Senator CLARK. There is another office where there are how many?

Dr. KOOB. Four.

Senator CLARK. Four others?

Dr. KOOB. Two independent besides those.

Senator CLARK. There are 12 or 14 physicians. That is remarkable. Do these other group practices have any satellite clinics?

Dr. KOOB. No, just ours.

Senator CLARK. So you serve these other two communities, Wyoming and Wheatland, one community about 800 and the other about 900. And who goes down to Wyoming? Do you do that or is there some rotation within the group?

Dr. KOOB. We try to rotate somewhat through that. I'm only there 1 day every 2 weeks, but—

Senator CLARK. Complete day?

Dr. KOOB. One full day every 2 weeks and then we have a full-time physician at that office.

Senator CLARK. I see.

Dr. KOOB. The other one, one physician is there on a Monday and a Thursday and the Tuesday and Friday kind of like that.

Senator CLARK. So there are three different physicians—

Dr. KOOB. Pretty much.

Senator CLARK [continuing]. That provide service, physician service, all day long every day in Wyoming?

Dr. KOOB. Except the weekend.

Senator CLARK. Except the weekend. And now, when is Joan Wentworth there as a nurse practitioner?

Dr. KOOB. She doesn't go there.

Senator CLARK. She's in Wheatland. So there is no other physician's assistant or nurse practitioner? It's full-time physician in Wyoming.

Now, let's look at the same thing in Wheatland. Do you have full-time physician service in Wheatland?

Dr. KOOB. I'm there on Mondays and Thursday.

Senator CLARK. All day?

Dr. KOOB. All day. Joan is there Tuesday and Friday all day, and every 2 weeks our surgeon is there part of the day on Wednesday.

Otherwise, Joan is there. Then whenever she is there she is available to the rest of us by telephone if she has problems.

Senator CLARK. So you have physicians about half of the time in Wheatland and the rest of the time Joan Wentworth is there as a nurse practitioner. So you have full-time coverage—

Dr. KOOB. Right.

Senator CLARK [continuing]. Of one of the two of you or one of the three of you, so to speak.

And part of that time, as I understand it, Bob, for several years there was just no service at all.

Mr. STANKEE. That's right.

Senator CLARK. Now, I wanted to go into, Dr. Koob, for a little bit the reasons you think that Wheatland and other communities of that size without a hospital are not able to attract young physicians. It is a well-known fact that they are not able to and there are 160, I think, that are looking right now.

I was raised in a community of 490. We even had a physician until about 1946 or 1947 and Dr. Parker died. And we have never had a physician since. Why is that? As you talk to your colleagues why are they not willing to go out into a solo practice in a nonhospital community in Iowa and across the country?

Dr. KOOB. There are a couple of reasons. I just recently finished my internship in July of this year and I look back at some of the reasons why a young man does not want to go into a community. One of them is education.

You are alone in a community. You don't have any day-to-day contact with any other physician and you just rapidly stagnate yourself as far as continuing medical education. Sure, you can go to conferences and pick up, but whenever you do you are leaving that community without a doctor again. And it is just not as good as day-to-day education services.

Another reason is that with a few exceptions most schools, medical schools, don't teach any primary care to speak of. They teach hospital care. Most of your clinic services are through hospital services. You rotate through internal medicine. You rotate through surgery, but very seldom do you rotate through any primary care. And if you don't rotate through primary care, you don't have any feel for what primary care is like because it is a whole different ball game than hospital care.

You see a lot of routine things. You don't see a lot of excitement. And a lot of physicians don't like that kind of thing. Those are the two biggest reasons that I feel that younger guys don't go into small towns.

Senator CLARK. Professional isolationism or isolation, I should say—

Dr. KOOB. Yes.

Senator CLARK [continuing] from other doctors so that you are much more attracted to going into a group practice.

Dr. KOOB. Right.

Senator CLARK. Even if there are two or three.

Dr. KOOB. Right.

Senator CLARK. And the more doctors that are there, the more confident you are that you are going to provide quality service.

Dr. KOOB. Quality service and time off. If you are working 24 hours

a day, you are just not giving the quality care than if you were working less than that.

Senator CLARK. And you want to be around a hospital.

Dr. KOOB. Right.

Senator CLARK. Where you can take all the tests that are necessary and so forth. Those are the apparent reasons as you see it. So is it fair to assume that if we are going to have primary care at small communities that it is going to have to be done on the basis of group practices with a satellite?

Dr. KOOB. It has worked out well for us and I think it can continue to.

Senator CLARK. You are reasonably pleased with what has happened in the case of Wyoming and Wheatland?

Dr. KOOB. Very much so.

Senator CLARK. I gather from your answer then that you feel this can be a possible way for the whole country or a kind of model for the whole country—at least in some parts of the country.

Dr. KOOB. In some parts of the country. Maquoketa is in a really nice position because they have primary care but there is excellent secondary care within 40 miles to Davenport, and 30 miles from Dubuque. We are only about 30 miles from Cedar Rapids and then our tertiary care is only about 70 or 80 miles in Iowa City. So we have a really nice line of care in a reasonably short time span. We can get good care in any direction.

Senator CLARK. Well now, let me ask you about the nurse practitioner. You are working now with Joan Wentworth. Do you think that, in terms of your own experience, physician extenders such as the nurse practitioner in the satellite clinic is part of the solution to the health manpower shortage in small towns?

Dr. KOOB. It has helped us a great deal. Besides, just because it is a single small town doesn't mean it is the only one that has trouble recruiting physicians. We also have problems recruiting physicians. And if we could recruit more, we would.

She is a very valuable aid. She knows her limitations and she does them quite well. And as long as she does know her limitations like any physician, she gives excellent care.

Senator CLARK. So that if you did not have her out there working on that basis you just wouldn't be able to extend yourselves that far.

Dr. KOOB. No; we would be way too far overstaffed. As it is we are not overstaffed at all and it is a full-time job.

Senator CLARK. And what is that relationship now in working together? How do you draw the guidelines. Obviously the two of you together decide what you can do, Joan, and what you cannot do. Is that just a matter of judgment or is there some way you can draw that fairly clearly?

Dr. KOOB. It is difficult to do clearly. What Joan has tried to do over the years of her training is establish the limits, you know, what is normal and what is not normal. If it is not normal then she gets consultation and help. Routine things like colds and sore throats—

Senator CLARK. Like what?

Dr. KOOB. Colds, sore throats, that kind of thing are not a big problem. But if it is any farther into that, she doesn't hesitate to call and get any consultation.

Senator CLARK. So the patient could come back the next day or——

Dr. KOOB. The next day, or if it's serious, the same day.

Senator CLARK. How far are you from Wheatland?

Dr. KOOB. About 22 miles.

Senator CLARK. And how far is Wyoming?

Dr. KOOB. Twenty.

Senator CLARK. Twenty. And is that the closest group practice to those two communities or do they have some other place that is closer?

Dr. KOOB. Pretty much. Wheatland is closer to De Witt. They have some physicians there as you will hear.

Wheatland is in a little different position because they sit in a position where some go to Cedar Rapids to work. Some go to Davenport, some go to De Witt and that makes a difference where they get their health care.

Wyoming is a little more isolated so we have better care there.

Senator CLARK. Well now, let me ask Joan. What is your training over and beyond what you would have as a registered nurse to prepare you for this position which is really of a higher level? What kind of training have you had? Can you talk a little about that?

Ms. WENTWORTH. I had an extra year of training. And this I had to take in North Dakota because there is no place in Iowa to train nurse practitioners.

Senator CLARK. Is that right. There are no nurse practitioner schools in Iowa and there are only six of you practicing or operating. What's the right word?

Ms. WENTWORTH. Practicing.

Senator CLARK. Practicing in Iowa.

Ms. WENTWORTH. Right.

Senator CLARK. The only one in eastern Iowa. Do you know where the others are?

Ms. WENTWORTH. Yes. One is in Osceola.

Senator CLARK. Yes. We talked with the one in Osceola.

Ms. WENTWORTH. One is in Red Oak. There was one in Essex, Iowa, in a satellite clinic and there is one in the city of Des Moines and one up in Estherville.

Senator CLARK. I see. So about two or three of you are operating in this satellite clinic system.

Ms. WENTWORTH. Right.

Senator CLARK. So you took a year's additional schooling?

Ms. WENTWORTH. Yes.

Senator CLARK. What did you learn then?

Ms. WENTWORTH. When I was taught nursing, nurses did not diagnose and you never said, "This is so." A nurse always said, "This is possibly so" or "This appears to be." In this training they teach you to diagnose and they teach you treatment and they teach you management of illnesses and it's not—as a nurse you are following doctor's orders and as a nurse practitioner you are giving the orders.

Senator CLARK. Well, let's talk a little about that relationship because that is obviously what bothers physicians. You know, they say, "Well, we don't want these nurse practitioners or physician's assistants out operating on their own." I know that that is a delicate line to draw between what you decide on your own. But suppose you

have some doubt about a diagnosis. Suppose that there is some question, haunting question maybe, in your mind about what this really is. What do you do?

Ms. WENTWORTH. If I'm in the satellite, I get on the phone and talk to one of the doctors and explain what the problem is and what I find on examination and anything else that is pertinent. And many times the doctor can give me advice over the phone. If he feels that he should see the patient, then the patient either comes back the next day to see him or goes to Maquoketa that day to see him.

Senator CLARK. So if you have any doubt at all you check with the doctor.

Ms. WENTWORTH. Right.

Senator CLARK. Or you send them up or hold them another day if that is equally feasible. So that is a constant kind of judgment on your part: what you can do that is fully within your qualification and training as well as deciding whether you feel you ought to have someone with greater training.

Ms. WENTWORTH. And also in my training, the book learning part was in North Dakota but the practical part was here with these doctors so the doctors I work with now are the doctors who trained me.

Senator CLARK. I see.

Ms. WENTWORTH. And this gives a much better trust on each other's part because they know what I know and they trust me a little more because they trained me.

Senator CLARK. Now, how much of your time over a week is spent on your own, that is to say when you are not right in the same building with the physician?

Ms. WENTWORTH. About half of my time.

Senator CLARK. About half of your time, you say. And what do you feel that you are able to do for the citizens of Wheatland that would not be done if you weren't there? Suppose only the doctor came. Assuming he is working full time, he could come about half the time. Suppose you just weren't there half the time. Closing down the clinic, I guess, would be the alternative. What service do you provide in that half time when you are there that couldn't be better or just as well provided? Can you give us some examples?

Ms. WENTWORTH. Well, if your clinic is only open say 2 or 3 days a week, it doesn't—it's not going to continue to operate because in the meantime people get sick and they go some other place to a different town to a different doctor and they tend to stay with the same doctor. So if you don't have a full-time clinic, you might as well not have a clinic at all because it just doesn't work.

Senator CLARK. But I suppose in one sense one might argue that that is making the question because they can go to another physician to get equal care.

Ms. WENTWORTH. But they have to go further away.

Senator CLARK. Are they less apt to go?

Ms. WENTWORTH. Yes; because then that care is there and then that somebody is there.

Senator CLARK. So you think you get some people because you have a clinic in Wheatland. These people would not otherwise go to a physician because they think the doctor is just too far away or they

don't know if they are sick enough or they are too old to get around or don't have the transportation.

Ms. WENTWORTH. Yes. There are a lot of older people in the town the size of Wheatland and they don't have the transportation, and mothers with young children who it is hard to go a long way for care.

Senator CLARK. So they are more apt to go to the clinic when they need to go than they would if they had to drive significantly farther to a doctor.

Ms. WENTWORTH. And they would go before a minor becomes a major illness.

Senator CLARK. Does it make any difference that you have a clinic there is somebody has a heart attack and their heart stops beating or there is an accident? What is the difference in that evaluation?

Ms. WENTWORTH. There is a lot of difference because even though I'm not a doctor I can still do more than a lay person can. And we have facilities and we have medications and we, you know, have the telephone and we can do things that the ordinary person cannot do.

Senator CLARK. What if somebody in town—I'm getting in very dangerous territory here because probably there isn't anybody ever born that knows less about medicine than I do and I know it so maybe I am way off track here—but suppose there is a heart attack in Wheatland and the heart stops beating. Are you professionally capable of doing something to start it again?

Ms. WENTWORTH. Yes.

Senator CLARK. What?

Ms. WENTWORTH. Well, if the heart stops beating the first thing you do is make sure it stopped. The next thing you do is hit him on the chest. The next thing you do is make sure that he is breathing and I am qualified in all these areas.

Senator CLARK. If a doctor were not there could you provide some kind of shot or serum or something to stimulate the heart? Is that possible?

Dr. KOOB. It depends on what is available, you know. If you have got all the necessary equipment we have in the hospital in the emergency room, you can do that, but——

Senator CLARK. But when you are out in Wheatland yourself.

Dr. KOOB. I couldn't do a lot more than Joan could do. Just primary first aid.

Senator CLARK. OK. What about health education, Joan? Do you find it consistent with your duties to provide any health maintenance, health education, preventive medicine, to the community, the school, or to anyone at all? Can you do it at the clinic or are you pretty well tied down to the world of the clinic?

Ms. WENTWORTH. You can do a certain amount in the clinic. As you see patients this is the best time to do it because they are concerned about health at that time and they are there and it is easier to talk to them. We also do some public speaking and things like this in the community to help with preventive medicine and education in that area. So we do what we have time for.

Senator CLARK. Yes. Well now, finally, I guess this probably is addressed to both of you. One of the things that we are looking at most carefully is the possibility of getting legislation passed to reim-

burse services provided by nurse practitioners and physician's assistants for medicare and medicaid. What is your feeling about that, Dr. Koob?

Dr. KOOB. We spend, I think, it would be 2 to 3 days per month. We cover several nursing homes in Maquoketa in the satellites and other places with routine office visits because they can't get to the doctor. Nurse practitioners helping with this kind of thing would be really beneficial to our time. It would give us more inoffice time for acute illnesses and it would help with the health maintenance, preventive medicine in the nursing home areas.

Senator CLARK. So you think it would be very helpful to you?

Dr. KOOB. It would help.

Senator CLARK. Right now, if Joan serves older people or people that are covered by medicare and medicaid, that is not reimbursable at all.

Dr. KOOB. It isn't unless it is under you.

Senator CLARK. Directly under?

Dr. KOOB. She's doing it under us.

Senator CLARK. But the half-time that she is down in Wheatland on her own, if she is serving older people not directly under your supervision then her work is not reimbursable; is it?

Dr. KOOB. Well, that's, you know, a questionable subject.

Senator CLARK. It's debatable.

Dr. KOOB. That's touchy ground.

Senator CLARK. OK. I think that's all the questions I have. Thank you very much.

We will have the next panel. We will have questions after the last panel. Now we are going to hear from Dr. Smith, a Davenport physician who directs the family program; Earl Banks, the De Witt Hospital administrator; and Dick Mohr, mayor of De Witt.

All right. Now as I said earlier, this particular panel is going to be addressing itself to a rather different situation: the whole problem of having enough family practice residency people in the State. We want to know how we can attract more physicians to go into family practice rather than into the specialties which are usually centered in urban areas. This panel will tell us how they are particularly addressing that problem in eastern Iowa through the Davenport family practice residency program and how they are working with the clinic in De Witt, which we visited this morning, to provide doctors there and at the same time to provide training for physicians in family practice there. Then we will have some views expressed from the community through the hospital administrator there.

So, Dr. Forrest Smith, do you want to proceed and tell us what you are doing?

STATEMENT OF FORREST W. SMITH, M.D., DIRECTOR, MERCY-SAINT LUKE'S FAMILY PRACTICE RESIDENCY, DAVENPORT, IOWA*

Dr. SMITH. Sure. For those of you who aren't aware of what we are doing in Davenport, we are one of seven existing family practice residencies throughout the State. Six are directly affiliated with the

*See p. 310 for the prepared statement of Dr. Smith.

university. The one at Cedar Rapids is not and there is a formative program currently in process and possibly will be functioning in July of 1977 in Waterloo. We have been in operation in Davenport since July 1, 1975 receiving our first seven residents and during the recruiting process it became very apparent to me that over half of the candidates that I saw were coming from rural America. And listening to their goals, they expressed some preference to practice in rural America.

At that time I thought to provide a more comprehensive approach to physician education at the graduate level that we could provide an urban practice in a community the size of Davenport and potentially I would like to develop a rural solo practice so that we really could teach comprehensive primary care at all levels in both settings and made contact with the De Witt Hospital and its staff and administration.

Although the primary objective of the Mercy-Saint Luke's family practice residency is to train physicians in the medical discipline of family practice, an important and significant byproduct of this educational process is the many service benefits derived by the Davenport community and the surrounding rural areas. An innovative approach was formulated using a unique blend of community health services, medical and allied health education, and research oriented to a rural primary care delivery system.

On July 1, 1976, the Mercy-Saint Luke's family practice residency program opened a rural satellite clinic in De Witt, Iowa. Currently this health care facility employs one full-time third-year resident physician and one part-time staff physician. Working from the De Witt Family Medical Center, these physicians are providing comprehensive primary medical care to patients from De Witt and the surrounding rural communities.

Although the resident is still in training, he has no hospital specialty services to cover while on the rural rotation. He can thus devote his entire day to examining and giving care to patients in rural environments. Also, because he is a licensed physician in his third and final year of graduate training, his skills in ambulatory care have been developed to the point that he is quite medically competent.

Although based in De Witt, the programs would also be made available to the medically underserved areas of Malone, Low Moore, Welton, Charlotte, Lost Nation, Calamus, Wheatland, Lowden, Grand, Mound, and Long Grove. The combined population of this rural area is approximately 20,000 people. And I think it was identified as a potential service by a Dr. McQueen study done in the last several years.

To implement the rural rotation, we had to set up some objective and I would like to go over these and make a brief comment on each of these on what we hope to accomplish with our rural rotation.

The De Witt primary care system has the following objectives:

1. To deliver regionalized and comprehensive primary medical care to patients from De Witt and the surrounding rural communities;
2. To utilize extensively, various allied health personnel to extend the availability, effectiveness, and efficiency of the physicians in this medically underserved area;

3. To maintain a program of a consistently high quality of care and cost-effective nature;

4. To promote the team approach to health care delivery through interaction with various community health resources and education programs;

5. To serve as a demonstration model for the innovative delivery of ambulatory care in a rural setting.

I will expand briefly on these objectives and try to give you some idea how we are going about this.

Using the De Witt Family Medical Center as a base of operation, various medical care delivery programs will be integrated into a primary care system serving this rural area. Because the programs will be conducted by one single organization, the patients will receive comprehensive primary health care. This means one agency will be responsible for the screening, diagnosis, treatment, and if need be, referral of the respective patients.

Although the main emphasis of the proposal is on ambulatory care, the De Witt Community Hospital is available for any elements of these programs that necessitates in-patient and/or more sophisticated medical services. The long-term care unit of the hospital will facilitate the delivery of the various programs to the aged and handicapped of the area to be served without the patient having to leave his home environment.

Emphasis will be placed on the first contact medical care with responsibility for not only an individual patient but for his entire family. Because of the existing physician shortage in this rural area, traditionally the medical care administered was of an acute nature and limited to the therapy of a specific illness. In the proposed health care system, however, preventive medicine and health maintenance will be stressed.

It is estimated that the recently implemented satellite clinic will enroll and treat approximately 850 family units, or 2,550 patients during its initial year of operation. By the end of its second year this figure should increase to 1,000.

Because of the primary care physician shortage in this rural area and the fact that many aspects of patient care can be performed by nonphysicians, the proposed system will utilize extensively various allied health personnel to extend the availability, effectiveness, and efficiency of physicians. The project hopes to employ the following types of professionals: physician's assistants, registered nurse, social worker, nutritional consultant, patient care coordinator.

Patient health education programs are planned for the satellite practice. These will be patterned after similar programs currently being conducted in the residency program in Davenport. These educational sessions would be designed to foster the maintenance of health care and the appropriate utilization of the various health care resources.

Such programs would include classes in OB care, diabetic care, hypertension treatment, well-baby child care, and weight reduction. The staff physician, resident, and all other allied health personnel will share responsibility for these patient education programs.

Under our third objective, quality care, all physicians affiliated in the De Witt Family Medical Center are either board certified family practitioners or residents close to completion of their training in the

same speciality. A benefit of combining a health care service program with medical education is the quality of care.

A residency program combines the knowledge of recent medical school graduates with that of experienced practicing physicians. Because of the ongoing teaching, the most contemporary medical procedures, equipment, and philosophies are utilized. As in the parent office, the problem-oriented medical record is used in the De Witt practice. Using this system, the patient's history, therapy, treatment, and progress is thoroughly documented upon each encounter. There is also considerable audit and peer review among the physicians. These many considerations promote a constantly high level of medical care.

To make cost effectiveness, various means of enrolling and treating medically indigent people will be employed in the De Witt primary care system. This will include a program to make the medicaid-eligible people of the area aware of the assistance for which they are eligible.

The residency program will also negotiate with the medicaid intermediary, Blue Cross/Blue Shield of Iowa, to secure coverage for home health and ambulatory services as an alternative to that of in-patient treatment.

Under objective four, community health resources, although the community health resources are somewhat limited in the rural regions, the proposed primary care system will take advantage of existing relationships between the family practice program and various health oriented agencies in the Quad Cities. Many of the programs will be developed with the Community Health Care, Inc. It is anticipated that all major social services of Davenport are represented at the Community Health Care, Inc.

Although oriented primarily to care for the indigent population of Davenport, the community health care programs have been designed for the total health care needs of the community. The Mercy/Saint Luke's family practice residency program is currently working in concert with the CHC on several projects. It is anticipated that this relationship will be expanded in the future as the residency program expands its medical service to Davenport and the outlying rural areas.

To promote medical and allied health education, the program was designed with community health services in mind. The De Witt primary health care system will also have several beneficial provisions relative to the education of health professionals.

The residents will gain exposure to the idiosyncrasies of health care delivery in a rural setting. Studies have shown that 70 percent of the physicians elect to practice where they took their training which, I think, is a major thing that we should be looking at.

Senator CLARK. What percentage?

Dr. SMITH. The national average is between 60 and 80 percent. That's the last statistic I have and we have nothing to document that in Iowa because we have not been in operation that long. And hopefully, the resident will practice in a similar setting on completion of their training because the resident and his family will live in De Witt. They will become totally aware of the benefits a small rural community has to offer.

From a professional standpoint, the residents will learn to practice medicine with somewhat less sophisticated facilities and equipment

than perhaps he was accustomed to in the medical school and previously in his residency.

The allied health education program will also benefit from the proposed system. By incorporating nursing assistants, physician's assistants, and other health care professionals through the De Witt practice during their training may well provide the exposure necessary for recruitment to similar sized communities upon their graduation.

Objective five, to serve as a demonstration model and for research. Our rural primary health center is lending itself to various research efforts. This system could become a model for the delivery of care in a physician-short rural area. The unique blend of service, education, and research delivered in a rural setting could well prove to be a partial solution to the physician shortage in rural areas.

Because of affiliations in Davenport, there will be two distinct population groups—urban and rural. These two populations can be used for various studies contrasting the lifestyle of the urban and rural inhabitants. With our affiliation with the University of Iowa, expertise in research methodology could be easily obtained.

The Davenport program is currently using a disease index. Developed in conjunction with the university, this lists all patients with specific diseases. By using a similar index in De Witt, the contrasting environments can be used to trace their effect on disease patterns of the two populations. The Davenport program has also been active in computer simulation which would also be put to practice in De Witt.

I have tried to give you an overview of the development of the program and the objectives that we have. We are currently 4 months in operation and this is how we project the program will go.

Senator CLARK. Well, that is a good start. In fact, if we can have the statement for the recorder, I think it would be helpful. I have a number of questions I want to ask you but let's go on to Earl Banks, the De Witt Hospital administrator, to hear him talk a little about that community and their interest in health care and the relationship with this residency program.

STATEMENT OF EARL R. BANKS, ADMINISTRATOR, DE WITT COMMUNITY HOSPITAL, DE WITT, IOWA

Mr. BANKS. Ten years ago in De Witt and in the surrounding communities we had nine physicians practicing.

Senator CLARK. Ten years ago?

Mr. BANKS. Ten years ago, yes, sir. At the present time we have three and a half, Dr. Montz, Dr. Riedesel from in the Wheatland area is deceased. I think Dr. Montz is completely incapacitated. Dr. Peckosh in Lost Nation, I understand, is doing very, very little practice right now. Dr. Presnell in Charlotte is deceased and our wonderful Dr. Schafer from the city of De Witt is deceased.

About 8 years ago we started a very strong recruiting program for physicians to bring them into De Witt to serve De Witt and the total community. At the time we did we employed Dr. Gerhard Hartman of the University of Iowa to come in and do a feasibility study on physician recruitment, nursing home, building a clinic, and so forth.

Dr. Hartman's recommendation was that we build the clinic as we had suggested and right now we are kind of happy to say that we are in advance of many other communities in building a clinic as an

adjunct to the hospital. There have been several years that I've been very sorry that we had the clinic and spent the money because it's been—our recruiting program has been very depressing.

We did manage to attract two physicians to De Witt. One came in 1972 and this young lady was a Filipino who had 4 years of residency in pediatrics and she agreed to come in as a general practitioner. Six months later she decided she only wanted to do pediatrics which is right and proper and we should have known better and she moved to Davenport. That is Dr. Aida Belarmino.

In late 1972 an internist came in and I won't even try to remember his name—Dr. Peter Mangawang. He was an internist with 4 years residency in internal medicine and several months later he decided that he did not want to do general practice. It was not for him and so he, also, moved to Davenport, and since then, elsewhere.

Our clinic stayed empty for about 2 years. I would imagine that I have written probably 500 to 600 individual letters to doctors. I was in touch with Dr. Rakel at Iowa and Dr. Bob Rief at the University of Minnesota who both gave me lists of their family practice residents and we wrote to each and every one of them with no answer, the same as Mr. Stankee reported. There are very few replies that you get when you do write even though we had fliers on many of these from the IMA and the AMA.

Senator CLARK. How large is De Witt?

Mr. BANKS. De Witt is about 4,000.

Senator CLARK. So with 4,000 people you had a modern hospital and nursing home and other facilities?

Mr. BANKS. Right. The problem with physicians, in my opinion, coming to De Witt is the lack of a group practice. We had, as I say, three and a half, let's say four to keep it whole—four doctors who were not interested in starting a group practice. They essentially do work as a group. They cover each other when on vacation. They cover each other on weekends, on nights, and so forth. But they are not incorporated as a group practice per se.

Dr. Christiansen who is in Grand Mound has, for many years, covered much of the western part of our area. And in fact, I believe that he has the majority of residents at the Colonial Manor, Wheatland's nursing home. I believe he is attending physician out there.

Dr. Smith approached our hospital in either late 1974 or early 1975 with his proposition. Since we are a rural area, since we did have the hospital which had been inspected by him and his committee, it seemed appropriate to his type of program. They were looking for one in which a young physician could come in, practice, learn the rural practice—what he has to go through, the trials and tribulations that possibly he would be going through. Possibly this would be the place that he was looking for.

This was a great boon to us who had set there for 2 years, and the building had cost \$200,000 and it was empty, and we had not been very successful in any of our ventures. The hospital board of trustees agreed. The medical staff was in total agreement. And the medical staff of De Witt voluntarily is available for consultation to young physicians who come there.

I am very happy to say that we have flagged two of the physicians who are coming through. One we acquired before he got into the family practice and this is an individual that the city of De Witt loaned money

to get through his last 2 years of the University of Iowa with a promise from him to come to De Witt for not less than 2 years after completing school. Dr. Bower has decided that he would like to get through the family practice residency program, become more sophisticated, and the Chamber of Commerce and the mayor's department said, "OK. We will put you off for 3 more years before you come."

Senator CLARK. Now where is he?

Mr. BANKS. He is at the Davenport Clinic.

Senator CLARK. And is this his first year?

Mr. BANKS. Yes. Since then, we have talked with one other individual and we pretty well have him flagged down to come in June of 1978.

Of course, this is ideal for us to obtain physicians. Now, the two fellows that we have are very compatible. They will, I believe, be into a partnership and I think this could build to where if we did get a group, we would be in just great shape.

I think one of the big problems of single doctors, solo practice, and of people going into the group practice is the expense of getting the group practice started. The young physician coming out, he wants to come in—this is my opinion—sit behind the desk, start practicing and seeing his patients. He's not interested in having to hire people to have the floor swept, to get medication on the chart.

Senator CLARK. In other words, he wants to practice medicine rather than deal with the business aspects and the administrative aspects.

Mr. BANKS. And this, in my humble opinion, will be one great way in which help would be appreciated with a group practice in a rural area, if this type of system or subsidy could be given to some facility such as ours.

We have maintained a modern facility including a coronary care unit, surgery, etc. We have excellent consultants in Clinton. In fact, we have specialists in almost every one of the specialties, who do come out from Clinton. I'm happy to say that Dr. Milton Barrent is visiting here. He is from Clinton and has been our general surgeon for, I guess, 18 years, 20 years now.

Senator CLARK. How often does he come out?

Mr. BANKS. Any time we want him and this is 2 o'clock in the morning or at 3 o'clock on Thursday afternoon.

Senator CLARK. On the basis of need?

Mr. BANKS. We average right now about 260 surgeries a year.

Senator CLARK. Oh, really?

Mr. BANKS. I think these are my thoughts on the family practice program and of just how much great good it is going to do to our community. Before they came we actually had no view of getting a new doctor to come in on his own. They just don't want to do it.

Senator CLARK. Thank you very much. Let's hear from Mayor Mohr. I know the community has been active in these efforts as well, so I'd like to hear about it.

**STATEMENT OF HON. RICHARD MOHR, MAYOR, CITY OF DE WITT,
DE WITT, IOWA**

Mr. MOHR. All right. Well, as was stated before, the city of De Witt, per se, is completely behind the program and as earlier mentioned, before the chamber of commerce started the program some years ago

to entice this doctor that is practicing now in Davenport in the clinic—but it shows that the community is willing, through the chamber of commerce and other groups, to back something like that, you know, to go in and say, "We will give you the financial assistance if you can give us some medical assistance." And I believe it shows that the community is really behind something they need.

I mean, let's face it. Medical assistance, when you need it, is the most valuable thing in the world. And we appreciate the fact that this family practice clinic has been successful.

But some time ago, you recommended something that maybe the Federal Government could do to help us. And the fact is the De Witt Community Hospital, the \$250,000 unit there, sat dormant for 2 years. And the fact that they did bring a new family intern in, there is going to be some expense involved before this thing starts to turn over. You don't want to say a dollar and cents profit, but a return equal to his investment.

Possibly the Government could look at something. Possibly the first year, if there is a deficit incurred. The second year the deficit is surely not going to be as much and the assistance needed is going to be less than possibly the third year. These kinds of things make it much more attractive in a hospital such as we have for the people involved to commit themselves to a community, and I do mean a community-type health program.

Wheatland has got probably a 25-mile drawing there and we feel as though we can provide the services required which we have the facilities to do. And we are working very hard in getting the manpower to power these facilities.

It is an awful waste to sit there, and recently ECIA in Dubuque—

Senator CLARK. What is ECIA?

Mr. MOHR. East Central Intergovernmental Association completed a comprehensive plan for the city of De Witt showing the population trends. And in the area of 49 to 65 and over we can account for roughly 39 percent of our population which is the group that is going to require our most concentrated health. And the group from 20 to 29, the birth there is pretty near 12 percent of the population belong to that. So strictly on figures, they don't show the full scope.

The community itself is doing, the city of De Witt has grown 13.2 percent; Grand Mound, 11 percent; Welton, 18.1. And this growth requires a professional-type help.

I feel we are fortunate with the family intern-type thing because we have got 24-hour-a-day coverage. We have got doctors that are trained in what they are doing. A person comes in there with a heart attack—I'm not talking of the one you are talking about where it quits, but if you come in with chest pains, you have got the coronary available, you have got a doctor available, you have got the facilities available right now. This is what I think we are well blessed with. The financial aid that possibly the Government could give us would be very beneficial.

One more little item. The city of De Witt right now is involved in an industrial development type thing and we have had a number of inquiries from individuals coming into the area. And one of the first and foremost questions is, "What kind of medical facilities do you have?" We show them the physical facilities which are excellent.

"What do you have for doctors?" We are a little bit on the short side right there and I think that this is the type thing that we have got to bolster up.

As I think you saw this morning, our physical facilities are excellent. Senator CLARK. Yes.

Mr. MOHR. And if we just can fill those facilities, I think we are in good shape.

Senator CLARK. Good. I might just say in passing that we would be happy to consider your suggestions. Frankly, I hadn't thought of that. The one thing we did, I had an amendment which was passed and now has been signed into law which does provide low-interest, long-term loans for the construction or remodeling of clinics. Funds have not been available in the past but would be available starting probably as soon as the regulations are written for them in the next 2 months.

But that's not quite what you are recommending. You are talking about deficits in the 1st year or 2. The only thing that I know of that would fit that at all is we have been looking in Traer, particularly, yesterday morning in our hearings with National Health Service Corps doctors.

You know, there is a program where the National Health Service Corps will pay scholarships for doctors, or in some cases, act as referral agencies for doctors. And if you contract with these doctors, if you are not able to get another physician, they are paid by, in fact, the Federal Government. The National Health Service Corps guarantees the physician's salary for the first 2 years. Now, a part of that is paid back by the local community insofar as they are able. And after the first 2 years, the doctor is paid entirely by the community. But that is another program that is now in Traer and in Toledo, Iowa, two areas in Tama County. There are some others in the State of Iowa.

In Rock Rapids and Eldora they have a similar program but it's a little different. And I think you are now started in a program here in De Witt with a residency that makes a lot more sense for you than going in that direction at this point.

Well, for the court reporter's sake, we are going to take about a 3- or 4-minute break, 5 minutes at the most and then we will have the questions.

[A 5-minute recess was taken.]

Senator CLARK. May I say come right on up to the front of the room so that we can have a nice discussion. Come right on up toward the front and we will have a nice friendly discussion.

Well, let me start back where we ended with Dick Mohr, the mayor of De Witt. Would you sort of run through for me again what the community itself has done, city council, perhaps or the community or any part of the community in terms of assisting with this one doctor's education and so forth. What has that been, exactly? Can you describe that?

Mr. MOHR. Well, we contacted the doctor—or the student at that time and sold him on the idea that if we assist you financially to complete your education, would you, in substance, agree to practice in the city of De Witt or the area of De Witt in a general practitioner's-type—a little country doctor-type thing? And I think that in itself shows the community is behind something like that.

The business leaders of the community know what we need to keep a vital city. Business doesn't make a community itself. You have to

have the city's professionals. And I think in that vein is the way we approached the idea. We have to have a doctor. We are willing to take chamber money—

Senator CLARK. How much do you feel you have invested in that particular position? Do you have any estimates at all?

Mr. MOHR. About \$11,000.

Senator CLARK. About \$11,000. And then you have a facility that he would come back to for a minimum of 2 years?

Mr. MOHR. Two years.

Senator CLARK. And the hope, of course, would be that he would stay there throughout his career.

Mr. MOHR. His home is in Clinton anyway.

Senator CLARK. In Clinton?

Mr. MOHR. Right. De Witt is a unique town. There is a lot of pride in the city of De Witt and we want to keep it that way. In order to keep it that way we have to have the service of the people we need. We must have some industry in the town and in order to get more, we have got to provide the professional-type medical treatment.

Senator CLARK. Now, I've heard it 100 times but exactly how far is it from DeWitt to Clinton?

Mr. MOHR. About 20 miles and about 20 miles to Davenport.

Senator CLARK. And those would be the closest other hospitals to your hospital?

Mr. MOHR. Right, of the major-type ailments. But we don't feel we have to go 20 miles. We got it at De Witt. All we have to do is staff it.

Senator CLARK. Right. Now, I understand, but I was just trying to think in terms of other hospitals, and also where the line sort of draws in terms of where people would go to De Witt as compared to traveling to Clinton or Davenport or other areas.

How far west do you go? If you go north to Maquoketa it would be the next closest hospital?

Mr. MOHR. Right.

Senator CLARK. And then west to—

Mr. MOHR. Cedar Rapids.

Senator CLARK. Cedar Rapids. I see.

Mr. MOHR. We are very fortunate to have an ambulance service, too, that serves the immediate area.

Senator CLARK. Are the ambulance service people trained in emergency care and so forth?

Mr. MOHR. Yes, sir. The State regulations being as they are, board training required every year, but they are qualified and trained. Equipment wise, they are in topnotch shape.

Senator CLARK. Okay. Now, Mr. Banks. If you could look down for the next 10 years or so, what would you like to see happen in terms of number of physicians, type of physicians and so forth at the clinic that we toured this morning in De Witt?

Mr. BANKS. In the next 10 years what I have been very much hoping for is that possibly in 10 years—I've got to approach this in 2 ways.

Two of our physicians have passed 60 years of age at the present time. And so including a replacement for those two, hopefully, if we could get eight physicians in the next 10 years to give them each a year or so or more to build their own practice would help. I think that

the study made by Dr. Hartman set up a trade area for us of about 20,000 people with the national average of one physician for 1,000. I think we could very well handle that many and I think that the clinic would be a great thing for De Witt, of course. But we are not talking clinics this morning. We are talking patient care.

The kind of physician required is predominantly the family practitioner, possibly. I'm sure that Dr. Smith could answer that better than I, but I mean that six or seven family practitioners could well support a surgeon, a general surgeon. And I'm sure that they could well support a pediatrician. But I think that for more specialized care that we would use Davenport as the secondary-type care and Iowa City as a tertiary care area as we do now.

Senator CLARK. What is the difference between primary care, secondary care, and tertiary care?

Mr. BANKS. Primary care—it is a difference in the sophistication of the three and the equipment which you might be able to use for caring for various type patients.

Senator CLARK. And just to be sure we understand, how many primary care physicians do you have in De Witt now?

Mr. BANKS. Three and a half.

Senator CLARK. Three and a half with three full time and a doctor who is there on a part-time basis? You have a resident in addition to that but two of those three are over 60; is that what you said?

Mr. BANKS. Yes.

Senator CLARK. So you have to scout around now and get at least two within the next 5 years just to stay even.

Mr. BANKS. Well, we have got those two to stay even. Now we are going to try and get ahead.

Senator CLARK. Right. Right. What kind of an investment do you have totally in your health facilities in that one compound? You've got the hospital, you've got the clinic, and you've got the 50-bed nursing care—

Mr. BANKS. Right.

Senator CLARK. Facilities. What total investment do you have there?

Mr. BANKS. The nursing home which was completed in 1972, the total investment is approximately \$675,000. The doctors' clinic which was completed in 1971 is \$210,000. The hospital which was built in 1952—we were just talking this morning and it was about one-half million at that time which I would estimate would cost \$1.2 or \$1.5 million to build it today.

In addition, we have added a maternity wing in 1969 at \$90,000. We built a new heating plant last February at a cost of \$130,000. We have a power generator that comes on immediately with any down surge which cost about \$30,000.

So in the past, I can only talk from my own experience, but in the past 10 years we have spent about \$1½ million—\$1¾ million.

Senator CLARK. So you probably have got \$2½ million invested in equipment?

Mr. BANKS. Minimum.

Senator CLARK. And facilities and so forth for medical care?

Mr. BANKS. Yes, sir.

Senator CLARK. And the greatest problem in fulfilling the service, in providing the service, then, is simply the physicians themselves.

Mr. BANKS. Yes; to utilize the services. If I might, since June when Dr. Marme first came out, I could give you just a couple of statistics and these will not take long.

Senator CLARK. No; take as long as you like. I'd like to have them for the record.

Mr. BANKS. As to the increase we have had, in comparing with 1975 the same month, June of 1975, 392 outpatients. June of 1976, 587. And I must repeat again that the ancillary services from the clinic are furnished by the hospital. Lab and X-ray procedures are done at the hospital. In June of 1975 we had 1,293 lab procedures. In June of 1976, 1,920. In X-ray, June of 1975, 206; 1976, 296.

I could give the Senator a copy of this.

Senator CLARK. That would be fine. We could put them in the record.

Mr. BANKS. In outpatients this July of 1975, 381 to 637 this year. In August, 424 to 601 this year. In September, 486 to 546 this year.

The outpatient basis is primarily because we have one more doctor to see more people in our emergency room. And they do come into the emergency after hours. The laboratory procedures, again, these are all related. In July of 1975, 1,433 to 2,251. August, 1,212 to 2,203. September, 1,107 to 2,089. The X-rays of June, 179 to 335. August is 222 to 333. September, 201 to 280.

The income that this has generated for De Witt Community Hospital to override any moneys which we have expended for the clinic, startup cost and other costs, is well taken of, I believe. I doubt if there would be any great deficit.

Senator CLARK. How many people do you estimate that the hospital, clinic, and nursing home and so forth—how big an area do they really serve? How many people? You mentioned earlier the figure 20,000.

Mr. BANKS. Dr. Hartman's specifications in 1969, the survey was that we had a primary trade area of approximately 10,000 and a secondary trade area of approximately 20,000.

Senator CLARK. Do you have any idea how many? I don't know how you measure it, I guess.

Mr. BANKS. Geographically he was speaking of from Low Moor south to just west of Camanche on the east. North to Welton and out as far as Lowden to the west.

Senator CLARK. Now, what about nonphysician health personnel? Do you have any plans for utilizing a nurse practitioner, physician's assistants, any other kind of personnel which might be called, I guess, medical services? Do you have any people working in that level and do you plan to, and if so, who?

Mr. BANKS. Right now we don't have. We have a little different concept than the Wheatland Clinic in that it's a different concept completely.

Senator CLARK. It's a satellite clinic.

Mr. BANKS. Yes; we have the hospital where there are people on duty 24 hours a day. Our emergency room is manned 24 hours a day. Essentially, when the doctor's offices are closed we are immediately furnishing the nurse practitioner-type service, the immediate emergency service until the physician arrives.

Senator CLARK. And so you don't plan in the future, particularly, to have any additional services?

Mr. BANKS. At the present time we are not planning. We do have the ancillary services, of course, of dietary, pharmacy, and so forth already in our program.

Senator CLARK. Do you see any special advantages in terms of better health services in terms of having the clinic and the hospital and the nursing care adjacent to one another, connected to one another?

Mr. BANKS. Yes, sir, I do. The nursing home, of course. The philosophy of the board of trustees and my own when we built the nursing home as an adjunct No. 1, we had the medical care immediately available for those individuals should they need it. If they have to go to a hospital we do not have to call an ambulance and transport them. We put them on a cart or wheel chair. If they need laboratory procedure we can do the same thing without having to call an ambulance or some other type of transportation.

In having the clinic immediately adjacent we feel that in the case of an emergency we do have a doctor physically present on the premises and in no time that individual can go into our hospital emergency room. Probably 10 seconds, 15 seconds he can be there.

Senator CLARK. Before we go to Dr. Smith, just a couple of other questions. Did you ever have doctors that you were interviewing earlier when you were trying to get physicians to come there who said, "Well, we just don't think your hospital is large enough, the facilities are not adequate to satisfy what I'm trained to do or want to do"? Is that any part of the reason?

Mr. BANKS. No, sir. I have never had one say that. We have had probably a dozen physicians come in to visit us. We have offered a guarantee. Our last one was about 3 years ago. We have offered a minimum guarantee of \$30,000. That was guaranteed by our board of trustees. They were willing to make this knowing that we would have no problem meeting the minimum.

I could give figures on two physicians who were there which would point this out. Dr. Aida Belarmino who, again as I said, through her year decided only to do pediatrics had about \$44,000 in the year that she was doctor. Dr. Mangawang had within his 7 months almost \$30,000.

And so we have no fear of losing any money by making this type of guarantee.

Senator CLARK. But even that guarantee was not attractive enough to—

Mr. BANKS. Money doesn't seem to be the point today. The point is the time off, the leisure time that the individuals may have.

Again, I must go back to the group practice concept of where they don't have to worry about this type of—

Senator CLARK. Right.

Mr. BANKS [continuing]. Activity.

Senator CLARK. Let's talk now with Dr. Smith. Actually, let's just talk a little bit about this whole concept of family practice residency in Iowa and where we hope it will go and what we hope it will do.

Just for the record I wonder, Dr. Smith, if you would tell us what a family practice residency is, just in the most basic way.

Dr. SMITH. In 1969, family practice became a medical specialty, prior to 1969 there were 2-year internships that were called general

practice residencies. And they really did not turn out the type of product that we were trying to put out. No one had put any emphasis on ambulatory health care delivery.

In 1969 family practice became a specialty at the same level in the American Medical Association as pediatrics, anesthesiology, and so forth, and created the American Board of Family Practice. After 1978 you will not be able to become a board certified family practitioner without 3 years of formal training. That's post M.D. or post D.O. People like myself who are board certified, had to have a minimum of a 600-hour postgraduate study and be in practice 6 years before I could write the exam. And there is no grandfather's clause. You must write 2 days of exams and you are only certified 7 years as a specialist and must be reexamined.

Senator CLARK. Just to go back a ways to get this historically straight, what course of study or what was the designation of the old family doctor that lived out in these small communities and operated pretty much out of the black bag?

Dr. SMITH. General practitioner.

Senator CLARK. General practitioner. And that's the term that was used. Does the family care physician really replace the term general practitioner?

Dr. SMITH. Probably supersedes it. Not as the GP we knew of the past.

Senator CLARK. Is there such a thing as a GP now?

Dr. SMITH. There are a few functioning as yet.

Senator CLARK. I don't mean practicing. I mean graduating.

Dr. SMITH. Yes; you may go into general practice at this point in time after 1 year's graduate study at the intern level or first-year resident. All States, I believe, all 50 now require 1 year of graduate study after completion of the degree and you may obtain State licensure.

Ten years hence, my feeling is that will not be valid.

Senator CLARK. There are still a few now?

Dr. SMITH. You may still finish 1 year and go out into general practice.

Senator CLARK. What happened then in the last couple of decades? I assume that maybe 30 years ago, at the end of the war, would a majority of the students that graduated have been in general practice or had a high degree of specialization occurred by that time?

Dr. SMITH. The latter part of the century is when we began to see the area of specialization.

Senator CLARK. I see. So that became increasingly more and more students tended to go into specialization in the period of the last 25 years?

Dr. SMITH. Exactly.

Senator CLARK. And at the height of that period, which I gather would have been 2 or 3 or 4 years ago—do you have any idea roughly what percentage went into specialties?

Dr. SMITH. Prior to 1970 I think you can probably say that less than 5 percent went into general or family practice.

Senator CLARK. All the rest went into specialties?

Dr. SMITH. Right.

Senator CLARK. And is that a good part of the reason why small communities even the size of De Witt were not able to replace their retiring physicians?

Dr. SMITH. Certainly. You would never want a cardiovascular surgeon or an orthopedic surgeon in De Witt.

Senator CLARK. Right. So that it was just inevitable that as medical education became highly specialized virtually all students went into a specialty and the small communities were bound to have fewer and fewer physicians.

Dr. SMITH. You should probably have at least 25 physicians in the community with you to support an ophthalmologist.

Senator CLARK. Yes.

Dr. SMITH. And the family doctor we are trying to put out into our community now should be able to take care of 95 percent of your health care needs in your lifetime. That's not you; that's your family.

Senator CLARK. So the first and most significant goal is to try to solve the problem or at least alleviate the problem of health care in rural areas. To do that you have to produce more family practice physicians.

Dr. SMITH. Yes.

Senator CLARK. And that's what this program is all about that you are involved in.

Dr. SMITH. Yes.

Senator CLARK. And there are six of these in the State connected with the university, plus one in Cedar Rapids.

Dr. SMITH. Cedar Rapids, and Waterloo is in the formative stages; and if you take a radius, plot it around where the program is located we pretty well have the State covered if Waterloo fills in the blank in terms of the 80-mile radius we are talking about.

Senator CLARK. That would be a total of eight university programs?

Dr. SMITH. That would be eight. Seven university affiliated.

Senator CLARK. And the figures we got yesterday from Dr. Rakel from the University of Iowa who is apparently in charge of seven of these programs, all but the Cedar Rapids program—

Dr. SMITH. Right.

Senator CLARK [continuing]. Indicated that we have about, I think he said, 128 physicians who are now in this kind of family practice residency program.

Dr. SMITH. Exactly.

Senator CLARK. So the question is whether we are going to continue to increase those programs to produce more doctors who in turn, hopefully—we can't be sure they are going to stay in Iowa and we can't be sure that they are going to go to small communities, but the trend among the very few that have been graduated so far is in that direction.

Dr. SMITH. I think 25 graduated in the State last year and 15 stayed in Iowa and most of those in communities of under 30,000.

Senator CLARK. So that there is a very, very slight beginning trend, I think is about all we can say in that direction. And as I understand it, the numbers in the classes each year now are increasing?

Dr. SMITH. Right.

Senator CLARK. So there is some hope. Do you foresee the time, let us say in 10 or 20 years where communities the size of De Witt will really have an adequate number of family practice physicians so that

either through a satellite clinic or directly as in the case of De Witt, Maquoketa, and so forth, that we will really have an adequate number of physicians to serve this State and the country?

Dr. SMITH. That every one the size of De Witt is going to have one is very hard to say. When you talk in terms of 3,500, the fact you have good facilities, a good primary care hospital, and I think these young graduates want good hospitals and facilities if they are going to give the care that we demand in this day and age. I think chances are statistically good that we are going to see a complete reversal of what we have seen in the last 25 years in the downhill course.

I have permission from my board to extend my program from 12 to 24 residents by 1980. And if we look at the statistics of the Bicentennial Planning Commission, if I retain all trainees within this area, I still don't meet optimum physician/patient ratio. In 25 years or by 1985, even if our physician ratio right now is 1 to 11,300, and I'm talking about family doctors, it ideally should be 1 to 2,500.

Senator CLARK. In what area are we speaking of?

Dr. SMITH. In family practice. The ideal national ratio is 1 physician to every 2,500 people. And currently in the Davenport service we are at 1 to 11,300.

Senator CLARK. One to 11,300. Well now, you're really involved in the residency program. We had a young medical student at the University of Iowa who attended our hearing yesterday in Mechanicsville and he argued that changes must be made in the medical schools themselves, in medical school education, in order to acquaint students with family practice not just in residency but even earlier than that. He thought there ought to be more encouragement, more interest in getting people in family practice. Do you share that view?

Dr. SMITH. Very much. And that's probably why I'm doing what I'm doing today. The 12 years that I've practiced in Davenport, I've been actively involved in undergraduate medical education both in the program MECO you may be familiar with where they take young medical students between their first and their second year and put them in a community for a period of 10 weeks and expose them to the total community, it's medical education, and community orientation. And that started in Iowa probably in 1970, 1971 and since that time we have seen a reversal of the shunt. I've also participated with the university as a preceptor where every junior student must spend 2 weeks with a primary care physician in the State with him as part of that education. Schools who do not have that, do not have anywhere near the percentage of family doctors coming out of their class. I happened to go to school at the University of Illinois in Chicago and that was 15 years ago. And I probably could guess out of a 150 that there were probably 12 to 15 went into family practice at that time. And because of its urban location, it has not changed. However, now since Illinois has changed their health care delivery and medical education system and are starting to use Rockford or Springfield, and particularly Springfield School of Medicine which has graduated two classes, 50 percent of their class has been going into family care practice which, I think, gives you an idea that if there is early exposure at the community level rather than the highly sophisticated tertiary care centers, you are going to see a bigger family practice.

Senator CLARK. Isn't it true, also, that in many of these specialties there are more doctors than we need?

Dr. SMITH. Yes. We are overtrained especially in surgical areas.

Senator CLARK. Now, what do you see in terms of the Federal role, if any, in this whole business of family care physicians? What should we be doing at the Federal level? What should we continue doing? What should we stop doing? And what do you think we should encourage more?

Dr. SMITH. Well, medical education is an extremely expensive proposition. The last statistic that I have available to me to educate a family practice resident for 1 year required \$31,500, which includes their stipend.

Senator CLARK. \$31,500.

Dr. SMITH. To educate one doctor for 1 year. And I think the key to physician education is money, manpower and man-hours. These teaching programs are not economically productive and you can't make them service oriented when you are training physicians. And I think that we need continued Federal and State funding because they will never really become self-sufficient and still train physicians. You can't argue that the investment of Federal and/or State dollars, private dollars, whatever source of your dollars to train a physician who potentially will service the population for 40 years is not money well spent.

Senator CLARK. You don't have any idea where those students that you are now training in family practice will want to settle, I suppose. You don't have any idea whether they will stay in Iowa or go to small communities or not?

Dr. SMITH. Well, I have four Kansas and one man from Illinois.

Senator CLARK. In other words, we have attracted them from out-of-State to your program.

Dr. SMITH. We have four schools represented in my program. Last year I interviewed candidates from 18 schools. This year we are interviewing candidates from probably 25 schools as far away as Johns Hopkins, Texas, Washington State, Oregon, so we are seeing quite a different profile. Last year it was a 300-mile radius of schools and that has changed appreciably in this year's recruiting.

Senator CLARK. So you are getting recruits into the Iowa residency program for graduates of other medical colleges?

Dr. SMITH. Right.

Senator CLARK. You have no idea where they are going to go for sure?

Dr. SMITH. As I read my residents right now, I would guess that most of them from Iowa—and at least 7 of them are from Iowa out of 13, actually there are 9 from Iowa—will probably settle in Iowa. One has left the program. He graduated about 3 weeks ago Friday and he will set up a practice in Burlington. The next one will finish in March and he's probably going to Centerville, that's how he is oriented at this point in time. The two next summer, I don't know where they are going to at this point.

Senator CLARK. So you are reasonably optimistic that we are going to keep many of them and they are going to go into practice in smaller towns?

Dr. SMITH. If I didn't think this was the way to go, I would have not left the successful practice and jeopardized my wife and seven children to do this.

Senator CLARK. Seven children?

Dr. SMITH. Yes.

Senator CLARK. Let's hope you're right.

Dr. SMITH. I can always go to De Witt.

Senator CLARK. That's right. Well, now, let me ask you a different kind of question, a more difficult question, perhaps. Have you had any experience with the physician extenders?

Dr. SMITH. My experience, per se, has been extremely limited. When I was in the process of gearing up my program, I took the opportunity to go work at Williamsburg and Oakdale and I worked with PA students and family nurse practitioners in Rochester, N.Y.

Senator CLARK. Physician's assistant?

Dr. SMITH. Right. In Iowa a baccalaureate program which involves 4 years of formal training for a PA and they were given a degree. And they do have a pediatric nurse practitioner program in Iowa; but as for a family nurse practitioner, there is no family nurse practitioner program here. I did have the opportunity of working with two family nurse practitioners in Rochester, N.Y., one of whom was a woman about 50, extremely experienced; but from firsthand information, I really can't say what their skills are. I talked to the men in Muscatine who probably have 2 to 4 years experience and they are very high, I think, on physician's extenders but they feel that they should be in direct contact or direct physical liaison with the physician.

They don't have that much experience with independent duty as we are experiencing here in Wheatland and they are addressing their use on a one-to-one basis in the same physical structures. And the patient acceptance, depending on the area, ran between 60 and 75 percent well received by patients.

Senator CLARK. Yes; do you feel that that may be a part of the answer? Let me state it another way. You have stated that even with rather optimistic looks at these people that you are producing in this part of the State that are coming out of your residencies that it is difficult to see in this century enough physicians to really have a good patient/doctor ratio. Do you think in that interim period until we are able to achieve that, that physician extenders may be part of the answer, part of the solution?

Dr. SMITH. It's a potential area of solution, yes. But I think we have to be very careful if we have a population that is approaching zero and we are raising physician/patient ratio. I don't want to see them jeopardized to the point where they don't have a place to practice.

I guess for the 12 years that I practiced, I'd like to believe that my nurse was an extender of me once I became comfortable with her knowledge and skills in terms of what I would delegate.

Senator CLARK. Right. But you don't see us having too many physicians even with the more stable population in the next 10 or 15 or 20 or, I think you said, 25 years?

Dr. SMITH. I'm trying to sit down and think of a statistic. If we kept all trainees, I don't think we will ever hit it by 2000 if we would get the 1 to 2,500. At least 15 years we projected it out we have not obtained the optimum ratio.

Senator CLARK. Just a couple other areas of questions before we open this up. Do you think now we have got a lot of small communities,

communities of even 500, 800, so forth, who say, "We think we ought to have a physician?" Of course, they don't have a hospital or any other facilities. Do you think we are ever going to see the day or ever should see the day when all of these small communities each have a physician or two? Is that a feasible possibility?

Dr. SMITH. Communities 500 to 800? As I read my residents now, I would not say that they would be going to that small a community unless only a rotational basis, a part-time arrangement such as they are doing 1 day a week coverage, everyone takes a turn. They are going to have to have some method of cross coverage, but to go to 500 and especially in the solo concept that doctor's image is gone, and the mold thrown away. I don't think we will see that in this lifetime.

Senator CLARK. You are working very directly now with residents in family practice. These are the people, if anyone, who are going to go out to the smaller community. Can you tell us just briefly why these physicians are not interested in going out to a nonhospital, solo practice in a small community? What's their objection?

Dr. SMITH. I think I would reiterate what the previous physician said in terms of interaction. Once you finish medical school, you are a year behind. Medicine is extremely dynamic and to be competent, continuing your medical education is the key. You must never quit because it changes from day to day. And one thing that was not mentioned is the fact of where does your wife want to go? And when you are living with a person for 40 years and she has a fair amount of say as most of them do, the "cultural shock" or lack of cultural facilities and the proximity of the supermarket and/or the shopping mall—a certain amount of needs have to be met by their spouse. And I think they have a very important role. I look at a town of 1,000 and I could happily practice medicine there but I don't think my wife could have enjoyed it. I don't think that she'd still be my wife.

Senator CLARK. You say the social cultural isolation, but above it rates professional isolation?

Dr. SMITH. You need professional stimulation. I think you need interaction with peers. That's the key. That's why you are seeing group practice with us whether it's at the urban or rural—95 percent of my residents at this point in time want a group practice situation, some method to be Tom, dad, husband. They have other roles to fulfill.

Senator CLARK. What's the advantage of group practice?

Dr. SMITH. Time off. Time to study. Time to be Tom, dad, and husband, gardener. You can be a good physician, I think, but a physician who really doesn't get a break forever is really not doing himself or his patients a favor.

Senator CLARK. Well, let me try to give a summary of what seems to be developing between this panel and the other panels. We have had the experiences of Maquoketa, with the satellite clinic in Wyoming and Wheatland, with your family practice residency in Davenport, working with De Witt, and so forth to see whether or not you think this is the solution or at least part of the solution in terms of providing health care to this area or to other areas of the country.

It seems to me what we are saying is that we cannot expect to ever have a full-time physician in every community, in every small community. But what we can expect to have are group practices located

in larger communities, perhaps communities of 6,000 or more. That out of these group practices we may well be able to reach out to communities that are significantly far away, perhaps like Wyoming and Wheatland, through satellite clinics in which physicians are either full time or part time, perhaps staffed by physician extenders, nurse practitioners, physician's assistants, working under the direction of physicians. And that in this way we are able to, at least, establish central locations and perhaps satellite clinics out from that and in that way rural people can get access to health care on about the same level as people who live in metropolitan and urban areas.

Is that the answer?

Dr. SMITH. Potentially. I think if we create a situation where everyone was within 20 miles of some mechanism of primary care or 20 minutes, there is very few physical things that will really not wait—very few medical emergencies that will really be a fatality in 20 minutes. And even under the best circumstances, I am talking about in a highly sophisticated setting but I think you have to give some thought to the people who are not ambulatory, who cannot be transported. What the ideal mechanism for that is, I don't know.

Senator CLARK. All right. Well, let's stop at this point and let me say again that we have got forms here, self-addressed envelopes for anyone who wants to write out their testimony and it will be put in the record at the end of the hearing here as if it's been given.

Let's take a little time now and see if anybody wants to make a statement, whether he's involved in health care or not involved in health care. Just identify your name and address so we have it for the record and we would be happy to hear from anyone who has anything to say. Anybody care to say anything at all?

STATEMENT OF ROBERT TANK, BOARD CHAIRMAN, CENTRAL TRUST AND SAVINGS BANK, ELDRIDGE, IOWA

Mr. TANK. Senator, I'd just like to comment I happen to be on the board since last March with Dr. Smith. I have been somewhat interested because of my affiliation in the community. I have spent over 50 years in country banking and I know that you have seen me before.

Senator CLARK. Yes.

Mr. TANK. I'm sorry I was late today but I had to attend a Mercy Hospital Board meeting this morning and it somewhat delayed me in getting back here. I certainly wanted to be here. We naturally have a primary interest in developing country-located physicians. I think there is a real need for it without any question. And I certainly want to back Dr. Smith on expanding our facilities in Davenport which I happen to be a small part of. I know we certainly need the family practice type of physicians without any question and some possible Government support to help carry out the program. We do happen to have a doctor here in Eldridge, 10 or 12 years back had a population of less than 600 and we have 2,700 today.

We have a new community called Park View that's northeast of here about 5 miles, 10 years ago didn't exist and it has 2,000 population at the present time. We have another community north of here, Long Grove, between Davenport and De Witt. From clear across the county east and west we may have the only doctor in this area. There seems

to be a doctor out of Walcott which is west of Davenport about 12 miles but we certainly are feeling the need of it.

I don't pretend to know anything about medicine but I've got myself a little bit involved when I happen to be on the Mercy Hospital Board and I'm also on the Mental Health Center of Davenport some 10 years and have the privilege of being the president for a couple years.

I'm sorry, Dr. Smith, I can't attend the meeting tomorrow.

Dr. SMITH. He has a reason, though, Tomorrow is his 50th wedding anniversary.

Senator CLARK. I see. Well, congratulations. Well, we are pleased to have your statement. Let me ask you one question. Since you have worked in both fields, do you know whether the needs are greater in the family care areas than they are in the mental health areas, or are the needs great in both?

Mr. TANK. I would say the needs are great in both. I had no idea, Senator, that there was so many mental stresses until I got into that field. It just amazed me what the problems are.

Senator CLARK. Yes.

Mr. TANK. People who have an operation for appendicitis, they might talk about it to their friends and relatives; but if they have a mental problem, they would like to keep that under cover as much as they can, so it seems.

Senator CLARK. They are much less apt to have that taken care of.

Mr. TANK. That's right. I feel that Dr. Smith is doing a tremendous job here for us and I certainly would like to have him get all the possible backing that he can to carry on this program.

Senator CLARK. Well, thank you very much. I think that clearly one of the Federal responsibilities should be to sponsor and finance family care residencies if we are going to expect to produce the family care physicians that we need.

Would anyone else like to say anything? Yes?

STATEMENT OF RONALD W. PROBASCO, PROGRAM COORDINATOR, COMMUNITY HEALTH CARE, INC., DAVENPORT, IOWA

Mr. PROBASCO. I am Ronald Probasco, the coordinator of Community Health Care, Inc. As Dr. Smith indicated, the family practice residency program is working with Community Health Care to try and get a number of activities going in the Davenport area itself. One of the things I wanted to mention; that is, to reiterate, that the emphasis here is in terms of the need in rural areas.

As Dr. Smith indicated, the need in the urban area is great, also just as an example, in the Davenport area a survey that was done by a local area health planning council a couple years ago indicated that 40 percent of the individuals that reside in the inner city population do not have medical services available to them. They don't have the primary care physician. So, as Dr. Smith indicated, we are trying to develop programs for primary services.

Senator CLARK. Forty percent do not have any?

Mr. PROBASCO. They could not identify any private physician that they could call their family physician. That's of a population of about 18,000 in the inner city that was surveyed.

As a result of the need in the inner city population, Community Health Care was developed and we started a program to try and get services, medical services, as well as mental health, and social services, to the residents of Scott County. We hope to tie in the services Dr. Smith and a couple of others in developing satellite clinics in the future.

Another thing that I did want to mention is that the board of Community Health Care is very definitely sold on the idea that one of the answers to providing that type of service is through the use of physician extenders. There is going to be a heavy reliance on family nurse practitioners, pediatrician nurse practitioners, and physician's assistants in our program under the direction of physicians so that we can expand those services to the utmost. One key is financing. We do have tremendous support by local government to help us get started.

Senator CLARK. Thank you very much. Anyone else?

STATEMENT OF THOMAS FEDJE, EXECUTIVE DIRECTOR, MATERNAL HEALTH CENTER, DAVENPORT, IOWA

Mr. FEDJE. Tom Fedje. I'm the director of the Maternal Health Center, Davenport, Iowa, and we are providing family planning and maternal health programs. We are affiliated with the University of Iowa's OB-GYN department. We have medical residents in obstetrics living in Davenport. We have also physician's assistants rotating through for education purposes. We also have third-year medical students rotating through. We also use a family planning nurse practitioner who has training in obstetrics and gynecology. At this point in time we are using her primarily in the urban area of Davenport. The difficulties that we are encountering are finding a nurse practitioner to work rural areas and finding a physician to accept the responsibilities, Senator, for her in emergency cases in the rural areas. Without a supporting back-up physician she will not be accepted by the medical community.

In Davenport, with the use of a nurse practitioner our patient productivity has increased by approximately one-third. We last year had about 15,000 patient visits. In 1974 we had approximately 10,000 patient visits. One of the key factors, we feel, in terms of success in rural health care is leadership coming from your primary medical centers such as the University of Iowa which is a tertiary care center here in the State. Without leadership coming from the university, it's going to be very, very difficult if not impossible to change the system that we currently have established.

Senator CLARK. Good. Thank you. Anyone else? Yes.

STATEMENT OF LOUIS E. COCCIOLA, BLUE CROSS/BLUE SHIELD OF IOWA, CEDAR RAPIDS, IOWA

Mr. COCCIOLA. Senator I haven't heard this reason given by either of the two physicians here that have spoken on the panels regarding reasons that physicians give for not wanting to go into solo practice and be the only doctor in the community, but by the way, I am Ed Cociola, and I am in physician's relation with Blue Cross and Blue Shield, but I have heard doctors express fear of going into solo practice in small communities because of exposure to malpractice.

Senator CLARK. Yes; we have had some testimony on that.

Mr. COCCIOLA. You have had?

Senator CLARK. Yes.

Mr. COCCIOLA. Well, I was wondering.

Senator CLARK. In your own words, go ahead and express it.

Mr. COCCIOLA. Well, they feel they have more protection by practicing in a group and more particularly, they have access to immediate consultation.

Senator CLARK. That's exactly right. The consultation and association with the hospital which takes the responsibility of laboratory tests and so forth gives a greater feeling of security in what they are doing. Anyone else? Yes, sir.

STATEMENT OF TRUMAN A. WILKIN, MAQUOKETA, IOWA

Mr. WILKIN. My name is Truman Wilkin and I'm a practicing physical therapist in Maquoketa. I'd like to direct a question to Dr. Smith regarding whether this program has had any involvement with physical therapists to try and extend rehabilitative-type care to a person's home?

Dr. SMITH. The associate director of my program directs the rehabilitation program at Mercy Hospital. He is full time in the program and devotes probably 10, 12 hours a week to coordinating the entire program in setting up the program not only physical therapy, but occupational therapy and speech therapy. I asked of these modalities what should any resident learn in 3 years of formal training in terms of knowledge, attitude, and skills referable to your area concerning rehabilitation medicine.

This is not a mandatory rotation because I do not find each resident turned on by rehabilitation although it is a very integral part of their educational process. At this point in time I see the team either of OT/PT and cardiac pulmonary rehabilitation, it's really a completely dynamic thing and I'm seeing the residents' interest really generate with some enthusiasm. I think it is an integral part of any program.

Mr. WILKIN. One of the problems we are having is utilization and benefit to the patient and in doing that type of system of getting doctors acquainted with this. That's why I directed this question to you.

Dr. SMITH. That's why I said I asked them the terms of what knowledge, what attitude and what skills should they achieve. What is your job and how can I use you to help me and my patient?

Senator CLARK. I think you really have touched on an interesting point. I hope that at these hearings at some later time we are able to go into health care again.

We've talked about the attempts of physicians and physician extenders to get into the ancillary areas, homemaker health care, public nursing, and so many of those other areas that are really related to the question of rural health care. Also nutrition programs, and meals on wheels, as well as mental health and other areas, to develop an integrated rural health system.

Well, I want to thank Mayor Toneburg for the use of this hall and especially the witnesses that have come and taken the day, really, to give us the benefit of their thinking.

At this point, the hearing is adjourned. Thank you.

[Whereupon, at 2 p.m., the subcommittee adjourned, subject to call of the Chair.]

ADDITIONAL ARTICLES, LETTERS, AND STATEMENTS

THE UNIVERSITY OF IOWA,
Iowa City, Iowa, October 27, 1976.

DEAR SENATOR CLARK: It was a pleasure for me to participate as a witness at your rural health care hearing in Mechanicsville, Monday, October 18, 1976. As you suggested, I am forwarding some additional comments and figures to amplify points raised during the discussion.

The Family Practice Residencies in the Iowa Network affiliated with the University of Iowa College of Medicine (the Iowa Affiliated Family Practice Network) have been distributed in cities throughout Iowa and designed to involve students and residents in the surrounding communities. If we are successful in attracting residents to practice within a fifty mile radius around each site, the distribution of physicians graduating from these programs will cover the State fairly well. (See Figure 1) Studies by Yett and Sloan indicate the most significant factor determining where a physician will practice is the location of the final portion of his professional training—the residency. Figure 2 was developed when internships were still a separate entity. They have now been incorporated into the residency program and it is obvious that the residency is the most important factor; followed closely by medical school location, then birthplace. By distributing the Family Practice Residency Programs throughout the state we expect to motivate our residents to practice in that immediate environment.

Our purpose is to motivate through repeated involvement. This begins in the first year of medical school when students are offered opportunities to work in community hospitals throughout Iowa during the ten-week summer vacation as part of the Medical Education/Community Orientation (MECO) Program. The next opportunity occurs in the junior year when each student is required to spend two weeks in a preceptorship situation with a practicing primary physician in an Iowa community. A similar preceptorship opportunity is offered as an elective in the senior year, along with numerous other electives in communities throughout the state. Students who remain in Iowa for their Family Practice Residency Programs are offered additional opportunities during their second and third years to work with physicians in the communities surrounding the program. We are finding that residents do tend to return to communities they have worked in previously as students, either during the MECO Program or on their preceptorship; and this repeated involvement seems to be motivating them to select these areas for future practice. We feel motivation is the key to directing physicians to practice in these areas of need, and will result in a higher quality of health care provided by satisfied physicians who are there because they want to be and feel no coercion. Figure 3 shows the number and percentage of University of Iowa medical graduates who selected Family Practice Residency Programs. Most of these have remained in the State for their training and consequently are likely to set up their practice here. There are strong incentives built into the residency programs for graduates to practice in needy rural areas. The urging of the faculty added to the residents' realization of that need and their high degree of social responsibility has resulted in most of them practicing in rural areas. Nationally, 55 percent of all graduates of Family Practice Residency Programs have located in towns with less than 30,000 population. *In Iowa 79 percent of physicians departing from our Family Practice Residency Programs here located in towns under 30,000 population.* (See Figure 4) Of our thirteen graduates from the University of Iowa program in the past three years, ten have located in towns of less than 20,000 population and six in towns under 10,000. Since training in Family Practice is purposely directed to include a broad spectrum of medical skills and is intended to develop competence in all primary care areas, the Family Practice resident is the physician best prepared to deliver the breadth of care required in

rural areas. The population base in these small communities is not large enough to support the large variety of subspecialists who frequently end up providing this care in urban areas.

In 1973, when we were just developing the Affiliated Family Practice Network, we calculated the number of family physicians being lost in the State annually due to death or retirement and plotted the negative trend which had been underway for many years. Utilizing projections of the number of residents who would graduate from our new Network and the nonaffiliated programs, we calculated it would be possible to reach an ideal physician/patient ratio in Iowa (considered at that time to be one family physician per 2,500 population) by 1986. The ideal for rural areas is now considered to be closer to one family physician per 1,800 to 2,000 population. Since these projections were made (See Figure 5) the state's residency programs have developed to a larger capacity than anticipated. When all are functioning at full strength the State will be graduating 64 trained family physicians per year. These figures include those programs not affiliated with the University of Iowa, namely the Cedar Rapids Family Practice Residency and the Osteopathic Programs planned in Des Moines and Davenport. (Although practicing osteopathic physicians were included in the original projections, graduates from Osteopathic Family Practice Residencies were not.) As can be noted in Figure 5, the negative trend was projected to reverse and the State was expected to show a net gain of practicing physicians in 1976. This appears to have occurred primarily because a number of physicians trained elsewhere have been attracted to practice in the State, in addition to those we have been producing in our own programs. We believe that the well-developed network of teaching programs around the State, which enables physicians practicing in almost any community in Iowa to participate in a nearby teaching program, represents a very real attraction for those who train elsewhere. The availability of this professional stimulation is a most desirable feature for physicians practicing in relatively isolated environments. Because the Affiliated Network has grown to greater size than originally planned, we should attain the ratio of one family physician per 2,500 population earlier than 1986; and the more ideal ratio of one family physician per 1,800 population in Iowa should be reached prior to the year 2000.

Figure 5 shows the rapidly increasing number of Family Practice residents presently in training in this state. This is made possible by a combination of federal, state and local support. All three areas of financial support seem necessary for the continued vitality of such a program. Adequate funding of the recent Health Manpower Bill is a necessity. Iowa's program is additionally strong by virtue of the Iowa General Assembly's Family Practice Education Bill. It must be remembered, however, that Iowa communities sponsoring these residency programs continue to fund a major portion of their needs.

The Department of Family Practice has produced a film entitled "The New Country Doctors: Changing Concepts in Rural Practice," for use by rural communities looking for a physician. It illustrates recruiting methods which will be most effective in attracting the new family physicians by alerting them to the features these graduates look for and prefer. They are seeking an environment in which they can practice high quality medicine, and participate as part of a group practice of three or more physicians. They have little interest in being an isolated solo rural physician. The solo rural physician, so common in the past, is unfortunately still being sought by many rural communities. Since the average Iowan is no more than 15 miles from a community large enough to support such a group of physicians, we feel this solution is feasible. (See Figure 6) It is hoped our film will alert them to the changing nature of medical practice and the practice preferences of the new medical graduates. We have forwarded a copy of the film to Mr. David Harf for your review. The enclosed brochure will describe its nature and the method of rental or purchase.

I hope this information has been of some additional help to you. If I can be of any further assistance, please do not hesitate to ask. We appreciate your efforts in helping solve the rural health care problem and will do all in our power to assist you in this task.

Sincerely yours,

ROBERT E. RAKEL, M.D.,
Professor and Head.

Enclosures.

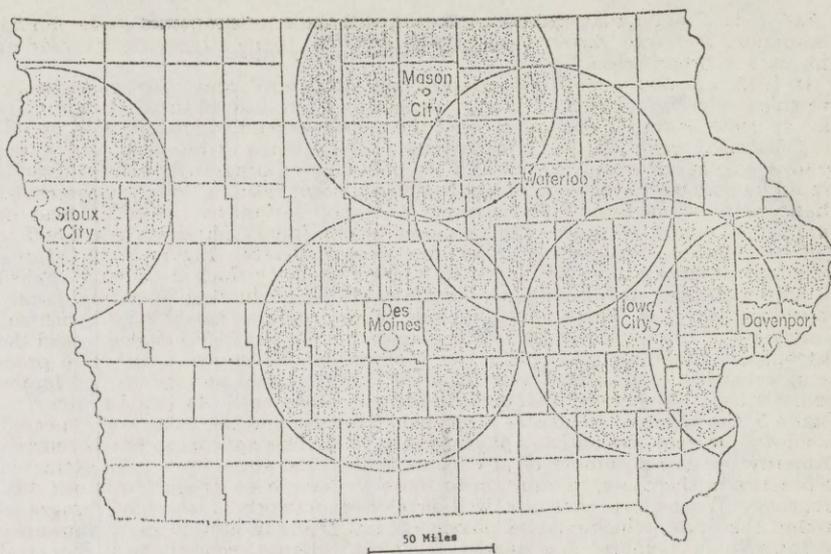
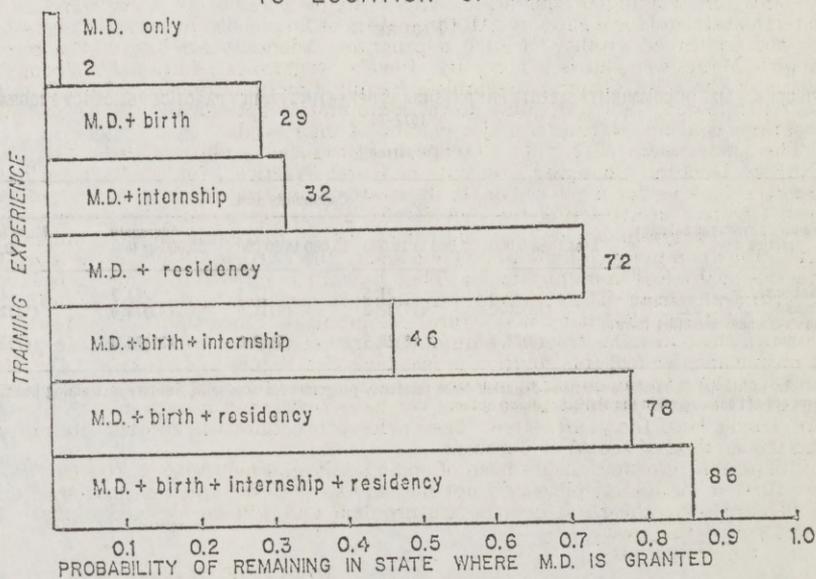


FIGURE 1.—University of Iowa affiliated family practice residency programs

THE RELATIONSHIP OF BIRTHPLACE & TRAINING LOCATION
TO LOCATION OF PRACTICE



From D.E.Yett & F.A. Sloan
Health Services Research Conference on Factors in
Health Manpower Performance and the Delivery of
Health Care, Chicago, 12-9-71

FIGURE 2

IOWA MEDICAL STUDENTS SELECTING CAREERS IN FAMILY PRACTICE
1970-1976
Iowa vs. Non-Iowa Residency Programs

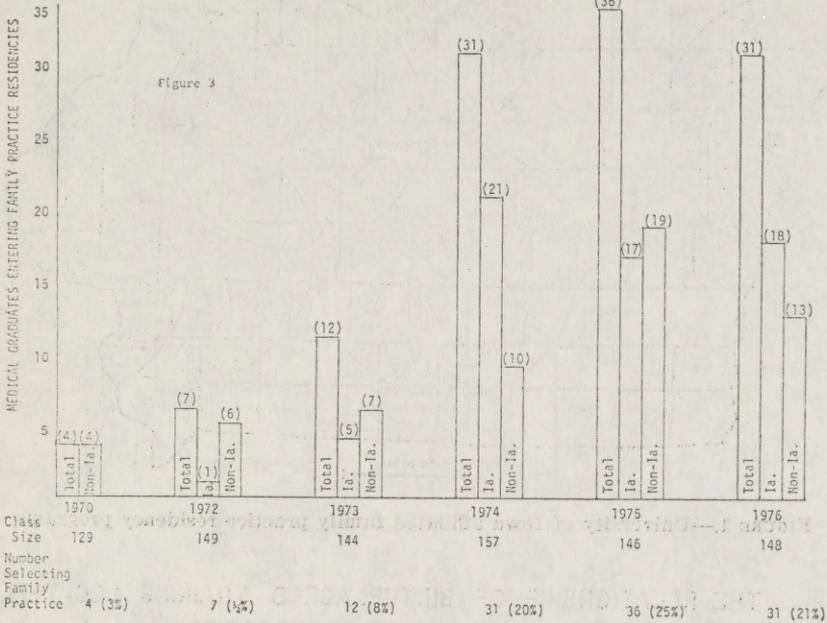


FIGURE 3

FIGURE 4.—SIZE OF COMMUNITY SELECTED BY PHYSICIANS DEPARTING FAMILY PRACTICE RESIDENCY PROGRAMS
1972-76

[In percent]

Family physicians selecting practice sites	Community size				
	Less than 5,000	5,000 to 15,000	15,000 to 30,000	Aggregate 30,000 or less	More than 30,000
National	16.3	21.5	17.1	54.9	45.1
Iowa ¹	(16)30.0	(17)32.0	(9)17.0	(42)79.0	(11)21.0
Iowa trainees selecting Iowa sites	(8)28.5	(8)28.5	(5)18.0	(21)75.0	(7)25.0

¹ An additional 12 family physicians departed Iowa residency programs for academic, military or training positions and are not considered in the statistics shown above.

Projected Increase in Numbers
of
Family Practice Physicians in Iowa
(Impact of Residency Program)

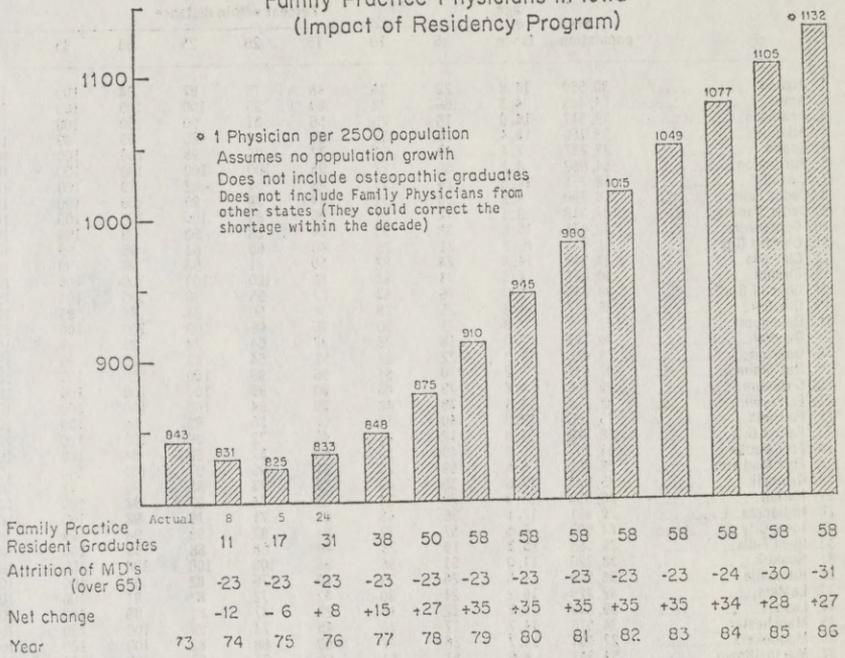


FIGURE 5

FIGURE 6.—PERCENT OF AREA POPULATIONS WITHIN SELECTED DISTANCES OF PRIMARY MEDICAL CARE¹

	Area population	Average distance	Percent within distance							
			5	10	15	20	25	30	35	40
1. Algona.....	30,550	14.8	22	34	48	75	87	94	100	100
2. Ames.....	64,483	4.8	66	79	89	95	100	100	100	100
3. Anamosa.....	32,517	14.0	18	25	56	81	90	100	100	100
4. Atlantic.....	33,160	15.4	25	33	39	64	86	95	99	100
5. Boone.....	28,237	7.4	49	64	77	94	98	100	100	100
6. Burlington.....	54,052	4.3	80	87	95	100	100	100	100	100
7. Carroll.....	38,753	14.8	26	35	48	61	82	99	100	100
8. Cedar Falls.....	65,790	8.2	50	59	64	88	99	100	100	100
9. Cedar Rapids.....	157,318	3.1	72	91	96	99	100	100	100	100
10. Centerville.....	30,071	15.5	38	55	74	88	98	99	100	100
11. Charles City.....	51,573	16.2	21	25	40	60	82	95	99	100
12. Clarinda.....	27,543	14.4	24	32	50	81	93	98	99	100
13. Clinton.....	58,055	4.5	71	81	86	100	100	100	100	100
14. Council Bluffs.....	88,030	5.0	76	83	87	95	98	100	100	100
15. Creston.....	35,677	16.8	25	28	38	50	84	88	99	100
16. Davenport.....	142,586	2.8	71	90	96	99	100	100	100	100
17. Decorah.....	70,153	22.0	18	23	37	64	78	95	99	100
18. Denison.....	28,405	15.3	22	32	51	64	83	95	99	100
19. Des Moines.....	297,832	3.2	70	91	95	99	100	100	100	100
20. Dubuque.....	99,456	4.8	79	86	90	95	100	100	100	100
21. Estherville.....	32,224	14.1	39	48	89	94	100	100	100	100
22. Fairfield.....	25,166	10.8	40	51	68	86	93	96	100	100
23. Forest City.....	28,172	14.8	18	26	48	78	86	100	100	100
24. Fort Dodge.....	64,207	9.8	49	58	64	82	88	94	100	100
25. Fort Madison.....	28,968	5.6	59	75	91	96	97	100	100	100
26. Grinnell.....	25,934	12.6	35	43	57	73	85	95	98	100
27. Harlan.....	26,059	13.3	23	34	59	74	97	98	100	100
28. Indianola.....	28,891	12.1	36	48	63	71	79	98	100	100
29. Iowa City.....	84,992	6.5	57	72	81	92	93	98	99	100
30. Iowa Falls.....	38,555	15.3	19	28	40	68	88	98	100	100
31. Keokuk.....	38,220	11.0	91	96	96	100	100	100	100	100
32. Knoxville.....	36,580	14.5	26	29	50	76	82	85	100	100
33. LeMars.....	42,729	16.2	21	30	42	72	87	92	100	100
34. Leon.....	39,299	25.2	12	16	27	47	81	98	100	100
35. Manchester.....	34,676	14.7	17	30	45	74	89	100	100	100
36. Maquoketa.....	27,494	13.7	26	42	50	68	82	100	100	100
37. Marshalltown.....	54,943	8.6	51	61	69	81	97	100	100	100
38. Mason City.....	60,350	6.9	55	74	83	90	97	99	100	100
39. Mount Pleasant.....	21,229	8.8	40	56	78	92	97	100	100	100
40. Muscatine.....	47,154	9.2	51	59	71	83	90	99	100	100
41. Newton.....	32,630	6.6	54	64	85	95	100	100	100	100
42. Oelwein.....	40,674	13.7	22	34	45	81	92	99	100	100
43. Onawa.....	28,836	20.3	19	24	35	48	81	90	95	96
44. Oskaloosa.....	31,592	10.8	44	53	70	73	86	97	100	100
45. Ottumwa.....	57,219	8.1	56	67	74	88	98	99	100	100
46. Perry.....	40,554	16.9	20	31	38	59	83	91	99	100
47. Red Oak.....	19,866	10.7	34	47	64	84	100	100	100	100
48. Sheldon.....	38,772	15.8	13	24	39	70	95	98	100	100
49. Sioux City.....	106,477	3.7	86	88	92	96	97	98	100	100
50. Spencer.....	33,947	12.5	32	41	58	72	92	99	100	100
51. Storm Lake.....	55,541	19.0	18	26	32	45	74	84	97	100
52. Vinton.....	35,291	16.3	16	22	50	66	78	92	100	100
53. Washington.....	26,284	12.9	27	37	61	82	89	93	96	100
54. Waterloo.....	103,235	3.4	74	85	88	97	99	00	100	100
55. Webster City.....	28,985	12.3	30	36	50	75	97	100	100	100
Total, State of Iowa.....	2,825,041	14.4			71		93			100

¹ These computations involve only 55 select Iowa communities where family physician services are available. Actually Iowans travel a shorter average distance to receive medical services because over 300 Iowa communities have physicians.

DEPARTMENT OF FAMILY PRACTICE,
MOTION PICTURE UNIT,
THE UNIVERSITY OF IOWA,
Iowa City, Iowa.

THE NEW COUNTRY DOCTORS: CHANGING CONCEPTS IN RURAL MEDICINE

Sweeping changes are taking place in rural medicine. More and more young doctors are entering the field of family practice and forming group practices with other family physicians. Rural communities are joining together to attract family physicians to their area and are sharing health services. The "old country doctor" is becoming a thing of the past.

The New Country Doctors: Changing Concepts in Rural Medicine was produced by the Motion Picture Unit in cooperation with the Department of Family Practice to explain these changing concepts and to assist rural communities in attracting medical services to their areas.

The film depicts differences between solo and group practice, changes taking place in modern medicine, and general trends of young physicians entering practice today. Emphasis is placed on the advantages of professional interaction in group practice as well as the manner in which the team approach allows physicians to provide high quality medical care to a large number of patients.

All inquiries regarding the use and availability of The New Country Doctors: Changing Concepts in Rural Medicine should be sent to the University of Iowa Motion Picture Unit, or the Department of Family Practice.

16mm sound/color—22 minutes—Rental—\$7.00—Sale—\$245.

SEPTEMBER 19, 1976.

DEAR SENATOR CLARK: I am sorry that I will be unable to attend any of your rural health care hearings which you are currently conducting in Iowa. No doubt you are aware of my continuing interest and vast experience in this area. I wish to offer here my ideas of what should and should not be done. First, three positive steps:

(1) The fee schedules which discriminate against rural practice must be erased. Routinely all insurers including Titles XVIII and XIX pay higher fees to urban doctors than to rural doctors for the same work. Urban doctors have offered convincing arguments for their higher fees but the difficulty in getting doctors into rural practice is an adequate answer to all such arguments.

(2) Adequate coverage of the smallest towns requires satellite offices staffed by paramedical personnel, generally Physician Assistants. Title XVIII and XIX are balking at paying for services performed by these paramedics. Ideally every rural town with a population of 1,500 to 4,000 should have a medical clinic with two to four medical doctors. Such a clinic should maintain dispensaries in all the surrounding small towns and staff them with paramedics. This would enormously improve the availability of care in the smallest towns and make preventive medicine possible.

(3) This profession is very vulnerable to tax incentives. I suggest that various tax credits be devised for doctors who carry out the government's programs. For example you might allow one tax credit for doctors in specialties the government chose to favor and another tax credit for doctors who practiced where the government wanted them. Some doctors would qualify for both credits. The first credit could be for all doctors providing primary care. The second would be for rural or "inner city" practice. I suggest that each credit be \$1000. This would cost the government about \$100 million annually in lost revenue, about \$4 for each citizen served.

Now for some things that should not be done.

(1) Don't put any government money into rural facilities. Such facilities are invariably over-built and under-utilized. Frequently they stand empty for years. Routinely the original cost of such a facility is \$100,000 or more and it is a bad investment.

(2) Don't seek short-term doctors. There are schemes to get doctors into rural communities for stints of two, three, or five years. This is horrible. It attracts the worst doctors and it is insulting to the rural population. Routinely when such a doctor leaves he can not be replaced and the facility stands empty. Good rural medicine cannot be practiced on such a short-term basis. It takes more than five years to get to know the town. Rural practice is a specialty and a career.

(3) Don't salary the rural doctors. This "turns off" the rural population and leads to rapid changes in medical personnel.

That concludes my ideas for the moment. If you have any specific questions feel free to ask.

Best regards,

C. E. BERRYHILL, MD.

HARRISON COUNTY DEPARTMENT OF SOCIAL SERVICES,
HARRISON COUNTY COURTHOUSE,
Logan, Iowa.

DEAR SENATOR CLARK: The last person to be heard at the meeting in Treynor was the only one to touch on Health Care given *in the home*. There were three

Homemaker Supervisors at this meeting and we would have liked to have followed through in In Home Health Related Care. I am enclosing an article which appeared last week as a supplement in all the papers in Harrison County. It explains, to some extent, the Homemaker program. We are very proud of this program and feel it is one of the best. It gives *direct* service to the people who need it and where they need it—in the home. Without the health care given, a large percentage of our clients would go to nursing homes, spend longer periods in the hospital, or, even as has happened in this county since the program was initiated in May 1974, expired if we hadn't gone to the home and found them. We credit ourselves with saving at least three lives, and possibly five.

I'm sure you would find the Homemaker (Home Health Aide) Program an excellent extension to already existing health care services discussed at your meeting. I could give you much more information but I know your time is very limited; however, I wanted you to know this program does exist and any thought you might extend to it would be greatly appreciated by our clients.

The other two enclosures are merely facts I gathered about Harrison County when we were writing up applications for Project Grants under Title III of the Older Americans Act.

Thank you for your time.

Sincerely,

Mrs. VIVIAN MOORE,
Homemaker Supervisor.

Enclosures.

MINI BUS SCHEDULES

There are 12 towns—divided down the middle by bluffs. 6 towns on West Side in need of transportation to Mo. Valley, the largest Town in County, population 3,500 and to Logan, County Seat, population 1,500.

There are 7 other small towns in area, all less than 300 in population; of these 7, only 2 have a Doctor, none have a pharmacy—2 do not have grocery store—5 do not have laundry facilities.

There are only 2 dentists in the County; 1 hospital in Mo. Valley; 249 people or handicapped people on SSI. Social Security man can be seen only in County Seat—1 day a week.

A mini-bus going from the County Seat of Logan making a loop through Magnolia Pisgah, Little Sioux, River Sioux, Mondamin, Modale, Mo. Valley, would cover approximately 65 miles round trip.

There are approximately 2400 people over 65—25% and 1600 more between 55 and 65.

PROBLEMS

1. Elderly and handicapped need transportation to Doctors, pharmacies, stores and business offices.
2. Many do not drive.
3. Many do not have the financial means to hire someone to drive them.
4. Elderly need to see Doctors more often.
5. Elderly and handicapped feel very dependent on others and sometimes hesitate to ask even though they need.

OBJECTIVES

1. To see that the elderly or handicapped can have available a mini-bus for transportation to fulfill their needs which cannot be done in their own small community.
2. To make the elderly more independent and not have to rely on neighbors or friends.

Handy Person

The homemaker and handyperson service is to help those who need help in maintaining themselves in their homes. There are jobs such as window washing, fixing roofs, mowing yards, fixing broken windows, repairs to their homes. Very hard for these people to do or to get someone to come in and do. Cost is prohibitive. Harrison County has a population of 16,000 and 12 town areas. 720 square miles that the handyman covers. He is now mowing 40 lawns and in the last 14 months, he has serviced over 100 homes in some manner.

Problems

1. One handyperson to cover this area is inadequate.
2. It would help if there was a fund to buy tools for the handyman at the present time he has to use his own. He doesn't have enough money for such things as, ladders, weed sprayers, hedge trimmers, which would make his job easier and faster.

OBJECTIVES

1. To obtain money to employ an assistant for the summer months when the workload is heavier (such as a boy from a low income family.)
2. The purchase of a few necessary tools to make for faster and easier work.
3. To give this service to the elderly or handicapped because of finances or the unavailability who cannot hire this work done.
4. Make them less dependent on friends and give them more pride in their surroundings.

MONTICELLO, IOWA, *October 21, 1976.*

DEAR SENATOR CLARK: I am writing in regard to your letter inviting comments and suggestions on rural health care in Iowa.

Rural Iowans are not always receiving really good health care, this is not obvious to most people who are not knowledgeable of what is available in larger health care centers. Many would rather sacrifice (unknowingly) the skill and equipment of the larger better equipped centers for the "hominess" and convenience of the local hospitals. This is not always a wise decision, the local doctors are often over-worked and somewhat behind on latest techniques and advances in treatment.

I am a Licensed Practical Nurse with experience in two larger hospitals and a small rural hospital and nursing home. While most of the health care personnel are conscientious, they are lacking in experience with up to date medicine, also the pay scale for employees is too low to attract the best unless they are not interested in driving any distance to a larger city. I would like to see better pay as an incentive to attract and keep better workers. I think the main answer to attracting better health care manpower is first and foremost—better pay.

I don't believe it is feasible to build, enlarge or equip elaborate small town hospitals, thirty or forty miles should not be too far to travel to take advantage of really good hospital and medical facilities. I will do that rather than accept less than good locally. Perhaps some form of public transportation could be arranged for those unable to find another way. There remains the problem of those unable to leave their homes for medical attention, even so they should have the services of a doctor not a paramedic in most cases. Perhaps public nursing could provide observation and checking of these people.

Thank you for your interest in this matter.

Sincerely,

NEDRA HANKEN.

COUNCIL BLUFFS, IOWA.

DEAR SENATOR CLARK: Although improvement in the quality and quantity of medical services in rural America is very important, it is essential that other aspects of health care receive increased attention and support from Congress as well as from the states. Medical care and health care are not synonymous and it is a real mistake to think that more medical services will meet all the health needs of America's citizens, whether rural or urban.

Among the health needs that people in America have today, nursing care ranks high on the list of needs for many people. Nursing care that is provided in the community is very important to rural areas. The most obvious role of nursing in the community is home health care, especially for the elderly and chronically ill. "Skilled nursing care" is the term used by the Social Security Administration to describe care directed toward treatment and cure of specific physical problem. Nursing care aimed at prevention of the same physical problem, which is no less a "skilled" service, is not reimbursable by the Medicare program. Only care which is directed toward the medical problem and is approved by the physician is reimbursable. The patient may have many other problems not related to the medical diagnosis, but nursing care for those problems is not recognized as valuable. It should not be necessary for the physician to "approve" the nursing care that will be given in order for Medicare to reimburse the nursing agency, in light of the

fact that the physician is not prepared to determine nursing needs and appropriate nursing intervention. Only the nurse is prepared to do this, along with the patient, and only the nurse is responsible for the nursing care she provides. Many people receive nursing care at their own expense or at the agency's expense because either the patient or his care does not meet Medicare requirements.

Aside from direct services to the ill person at home (of which nursing care is only a part), there are other less obvious roles for the community health nurse. There are many Americans who have never been brought into the health care system or have only sought care in a crisis situation and are never heard from again. Nurses can do a great deal to bring people into the system. Low-income families who see little value in seeking health care except for emergencies can be reached and provided with examination of the well child, immunizations, health teaching, counseling, and referral to appropriate resources for health problems. The well elderly population can be given examinations to detect early signs of disease so that early treatment can prevent further damage. Entire populations can be screened for diabetes and hypertension.

Health education, whether in group classes or individually, is provided in the areas of pre-natal care, infant and child care, living with chronic illness such as diabetes, etc. I am convinced that many problems are solved before they reach the point where medical intervention is necessary through the work of community health nurses.

Many basic public health services such as communicable disease control, immunization programs and public education programs are provided by nurses as well as other public health professionals.

My point is that the existing system is providing comprehensive, high-quality services. The problem lies in terms of quantity—there are not enough of these services. The most important reason for this is financial. In Iowa, there is very nearly no state funding for local health services. Many, many local nursing services have begun with federal grant funds, but at the end of the funding period the greatest share of the financial burden is on the county or city. This is why nursing services have not been able to expand enough to meet all the needs that they could. In Iowa there are six counties—Adair, Butler, Fremont, Greene, Guthrie, and Page—whose citizens do not even have one public health nurse providing basic services. Some counties have only one nurse to provide services to a population of over 12,000. I would guess that there are many states in similar or worse situations.

Nurses are the largest group of health care professionals. They are out there in rural America. The potential is great for providing sufficient quantities of services to meet many of the nursing care needs of our citizens of all ages. It is very exciting to consider new kinds of programs to improve health in rural areas, but it is also tremendously exciting and challenging to consider the scope of services that could be provided within the existing system.

MARY ELLEN MAXELL, R.N.,
Public Health Nurse Supervisor.

ST. JOSEPH MERCY HOSPITAL,
Mason City, Iowa, October 21, 1976.

DEAR SENATOR CLARK: I was unable to attend your rural health hearings due to conflicting plans. However, I have closely followed the news reports and read your Senate speech.

It certainly seems reasonable to assume that smaller communities who once had their own physician may not have one in the future. I agree with the development of physician extenders such as family nurse practitioners.

This is not a simplistic answer. The physician's assistant types must have the back up of M.D.'s within reasonable travel distances and with schedules that permit appointments on a short time frame basis. Otherwise we will layer the system and cause the individual with a medical problem that is beyond the skills of the "extender" to experience two fees and added delay in receiving needed care, rather than cost savings and prompt care.

I would also suggest that mechanisms be established to allow/encourage the nation's community hospitals to become a base for such outreach programs. If more and more agencies are established, with added administrative costs, to pro-

mote and supervise rural health programs, we will have added a questionable cost layer once again.

A close Congressional watch should also be maintained on the efforts of new planning and regulatory agencies established by PL 93-641. The complexity and numbers of reviews (5-6) that appear to be required before a needed new local health care service can be implemented and the potentially restrictive nature of ill thought through planning rules and regulations could seriously impede progress and artificially escalate costs.

It would appear reasonable to incorporate at least a portion of the physician extender training as a side element at the many new family practice residency programs now operating across the country.

The family practice physician will have to lead the way in rural health care delivery, and these doctors must learn to know and trust the physician assistants. Concurrent training in the residency setting, such as we have here at Mercy, seems to merit national exploration.

Numerous physicians I've visited with agree that selling the public on acceptance of physician extenders may well be easier than selling the physicians themselves.

A national task force of physicians, third party payers and rural hospital leaders could serve as a catalyst to seek solutions to the barriers and move at least rural America into the forefront of health care availability.

Sincerely,

GLEN E. HAYDON,
Director of Community Relations.

MOUNT VERNON, IOWA.

DEAR SENATOR CLARK: I want to thank you for the invitation to attend the rural health care hearings that you held recently. I deeply regret that I did not receive the communication in time to alter my hospital work schedule in order to make it possible to attend.

I am very concerned with health care in general but know very little about what type and quality of health care is being delivered here in Iowa. I did follow the article published concerning your comments following the hearings in Merville. I very strongly feel that nurses and nursing have an important role in the "satellite clinic" settings. I see this as an ideal way to make use of the skills and knowledge of the Independent Nurse Practitioner and the Family Nurse Practitioner.

Not having all the statistics and other data on hand, I would certainly suggest that it might very well be worth the time and effort to explore these two expanded nursing roles, to determine their adaptability for providing a larger rural health care work force. I am aware that there is some data available in the nursing literature that indicates the positive value of these practitioners in several areas of the country.

I sincerely appreciate being given the opportunity to express my ideas and opinions in this matter, although their factual basis is very limited. I will look forward to learning the outcome of the hearings.

Sincerely,

PHYLLIS LOWENBERG WOODS, R.N.

HEPKER CHIROPRACTIC CENTER,
Maquoketa, Iowa, October 22, 1976.

DEAR SENATOR CLARK: Attracting health manpower: six to eight years of college, accumulated assets, can all be wiped out with an unreasonable law suit. Malpractice! The patient should be protected but the doctor should also have reasonable practice protection. This is one reason for doctors going to larger clinics.

Financing rural health services: If we have a national health insurance and it is financed through a type of social security with private business as the carrier, we hope guide lines are set up so that these carriers cannot dictate how and when a supplier must use a diagnostic procedure such as x-ray.

Sincerely,

LEROY HEPKER, D.C.

DEPARTMENT OF SOCIAL SERVICES,
GREENE COUNTY OFFICE,
Jefferson, Iowa.

DEAR SENATOR CLARK: Having attended the hearing at Grimes, IA, on October 12, 1976, I was somewhat disappointed that the subject matter in almost its entirety was addressed to physician extenders and nurse practitioners even knowing this is a priority with you.

In the audience I recognized two public health nurses. What their particular area of concern was I do not know, but it could have been the same as mine—expansion and/or establishment of Public Health Nursing Programs as a means of delivery health care to rural areas.

There is no Public Health or Visiting Nurse in Greene and Guthrie Counties. Because of county budgeting problems it is not feasible at this time for the Board of Supervisors to fund the cost of a Public Health Nurse and the need to implement such a program is generally negative unless there is outside funds to assist in inaugurating and sustaining such a program.

As Supervisor for the Homemaker—Home Health Aide Program in Greene and Guthrie Counties, it has been impossible for us to accept medically-related cases as we do not have the resource of a Public Health Nurse or Visiting Nurse to supervise that type of care. The Home Health Aide service is reimbursable under medicare and would be most helpful to our elderly in remaining home longer or returning home from an institution sooner.

Do you foresee in your Health Care Plan monies allocated to instigate such a program? According to my latest figures, Greene and Guthrie are 2 of only 7 counties in the State of Iowa without this kind of rural health service. I would appreciate your comments on the above subject.

Also, I would like a transcript of the Grimes Hearing and the others when available. Thank you for your consideration.

MILDRED STANLEY, *Director.*

DEPARTMENT OF SOCIAL SERVICES,
CEDAR COUNTY COURT HOUSE,
Tipton, Iowa, October 18, 1976.

DEAR SENATOR CLARK: Thank you very much for offering me the opportunity to respond via the Rural Health Care Hearings regarding some of my concerns regarding the financing of Rural Health Services. There are several areas in which I see needs regarding health care for rural people. These are primarily in the area of preventive health care in order to maintain persons in their own homes and communities, thereby alleviating the high cost of institutional programs and permitting them to live in dignity as well.

The following are the areas of concern:

(1) Homemaker Home Health Aides.—Cedar County has at this time three Social Services staff person providing services to persons in their own homes within Cedar County. I see a need for more persons to provide this service, particularly to the elderly to maintain these persons in their own homes. A national mandate from the Congress to provide this service would obviously weigh heavily in the States' decision making process. In the current Title XX Program, Homemaker Home Health Aide Service is not a mandatory service, and in my opinion, it should be.

(2) In-Home Nursing Care Allowances.—Presently there is no way to provide payment to persons going into homes to provide In-Home Nursing Care for the elderly. Therefore, the elderly people and handicapped persons end up going to a nursing home where the cost is far greater.

(3) Custodial/Room and Board Homes.—More of these types of homes. It would be better for a person to be placed at this level of care than in a nursing home. As the situation exists now we have enough nursing homes but not enough facilities at this lower level of care.

(4) Health Screening Clinics.—Early and periodic screening diagnosis and treatment, as you know this program is mandatory under the Title XIX Medical Assistance Program which all families receiving Aid to Dependent Children are eligible. One of the problems in rural areas is having to utilize local physicians for this service. It is many times an inconvenience to the physician and an inconvenience to the Department to refer many persons to a variety of places. If it were possible to establish more health screening clinics, clients would be served much more adequately. This concern also relates to the next one, regarding Public Health Nursing Funds.

(5) Public Health Nursing.—This service in Cedar County is an excellent service. However, it is my understanding that financial support for these programs from the Federal Government is quite limited. Therefore local funding must many times absorb almost the total cost of these programs. This appears to be one of the problems in expanding Public Health Nursing Services in a rural area, even though many Public Health Nurses are needed the funds are not available. If a further Federal Match Program could be available to local governments more staff could be provided. As an example, Public Health Nurses, if adequately staffed can do the Health Screening that was mentioned above.

(6) Medicare.—I see a high priority for not only rural but urban persons as well that Medicare coverage be able to pay for drugs and dental work. Elderly persons in the rural areas benefit highly from this as they would from other National Health Insurance Programs.

(7) Medical Only Programs.—The states should be encouraged to provide Medical Assistance coverage for persons who are above the State Supplemental Security Income Level. This is one of the gaps in services. Many persons cannot afford medical care but are ineligible for Supplemental Security Income.

Thank you again for this opportunity to respond to your hearing request. I appreciate your concern regarding the rural health care and also your concern for other rural problems.

Sincerely,

LYNN M. DUNN,
Cedar County Director.

COUNCIL BLUFFS, IOWA.

DEAR SENATOR CLARK: The medical profession and medical schools need to place a greater emphasis on the area of preventative health training programs for physicians that treat the elderly. Older Americans comprise a high proportion of the population in Southwest Iowa and many are only able to receive crisis medical attention. I hope this Committee can encourage greater attention be paid to developing a preventative health care system that will improve the quality of life for older persons in this country.

In order to achieve the above goal, I recommend the medical profession and medical schools increase their efforts to recruit and train more physicians, physician assistants and nurse practitioners in the area of geriatric medicine. Increased use of emergency medical technicians in rural areas is also greatly needed.

FRANK F. KOWAL,
Executive Director,
Iowa Western Area XIII Agency on Aging.

AREA XIII AGENCY ON AGING,
Council Bluffs, Iowa, October 19, 1976.

DEAR SENATOR CLARK: The previous testimony has been most informative—as far as it goes. However, I find it lacking in the area of those older adults who are forced to cope with today's cost spiral while living on a fixed income.

As Information & Referral Supervisor for Area XIII Agency on Aging, Council Bluffs, Iowa, I am in close contact with areas of health need as they apply to persons 60 and over in the 8 counties that comprise Area XIII: Cass, Fremont, Harrison, Mills, Montgomery, Page, Pottawattamie and Shelby.

We must find a way to help communities that are in dire need of assistance to develop satellite clinics. We should be aware also, that Essex is one of the more prosperous communities for it's size in our State. This statement is not intended to slight Essex in any way, but to point out the fact that many of our smaller communities do not share that status.

It should also be pointed out that 2 of our 8 counties do not have Public Health Nurses. The need for Home Health Care is steadily increasing with more older adults remaining in their own homes as the age span lengthens. But Home Health Care is out of the question in the absence of a Public Health Nurse.

Doesn't it make good economic sense to provide home health care and thereby keep the older adult at home, rather than forcing that person into an institution at great cost to the family and taxpayer?

In the April-May '76 issue of *Modern Maturity*, page 8, near the top of the page—last column, Harriet Miller states and I quote:

"Yet less than one per cent of the money spent under the Medicare Program and less than one-half of one per cent of Medicaid funds are used for home health services. And a governmental study a few years ago indicated that up to 25 per cent of the older persons in nursing homes had no medical reason for being there!"

Why should these individuals be put in the hospital or nursing home merely because they need a simple shot once a day? Yet this does happen.

We do find that stumbling blocks are sometimes placed in the way when a Public Health Nurse attempts to help a great number of older adults with blood pressure tests. Many of these older adults are simply not able to pay the necessary \$8.00-\$10.00 office call fee just to have a blood pressure check and oftentimes there is a lengthy delay because of this. To be more specific: the Public Health Nurse in Montgomery County, working in cooperation with the Montgomery County Committee on Aging, had outlined a plan whereby Senior Citizen groups would be given blood pressure tests. Formulation of this plan had been the result of work done by a committee made up of Montgomery County Senior Citizens. However, doctors in the area would not allow it to be implemented. The Public Health Nurse put a sign in her office window: "Free blood pressure tests—walk in". For some reason, in only a short time, her office was moved from a ground floor location to the third floor of a building.

The doctors on the panel today lamented the fact that they work long hours. They are not alone in this aspect—at least they can and do make the necessary charges! Many of us work untold extra hours on a fixed salary. However, the doctor's workload could be lessened through utilizing the services of the Public Health Nurse and her health aides.

The discussion on the problem oriented records was most informative. However, there is a need for the individual patient to become acquainted with these records. He/she should be given some understanding of their illness. It is not uncommon for older adults to be "put down" when they ask for information.

In the past year there has been an increase in acceptance of the Home Health Service on the part of older adults and families while many doctors are still resisting use of this Service.

I would recommend that serious consideration be given to development of health services that are accessible to rural elderly enabling them to remain in their own homes as long as possible.

DARLYNE FRAZEUR.

ST. JOSEPH MERCY HOSPITAL,
Sioux City, Iowa, October 15, 1976.

DEAR SENATOR CLARK: In response to your letter of October 1, pertaining to a field hearing on rural health, we are pleased to have the opportunity to comment.

As the problems pertaining to the provision of basic or primary rural health services become more defined and well understood, definitive solutions also appear to be forthcoming. It is our position at St. Joseph Mercy Hospital that major institutional providers of health services, such as ours, have a moral and civic responsibility to assist in solving rural health problems. The Board of Trustees of our hospital has committed itself to a policy of involvement in rural health delivery activities. However, for maximum effectiveness, federal, as well as private foundation assistance, is needed.

After years of working with the problem of recruiting and maintaining physicians willing to serve in rural areas or even urban areas, such as Sioux City, we are convinced that the dollars are not the principal or exclusive motivator for young physicians. Our experience has shown that physicians are unwilling to locate in smaller communities because (1) the medical isolation they feel in terms of office coverage and consultation; (2) the frequent unavailability of specialized hospital facilities; and, (3) the frequent lack of availability to their families of cultural, educational, and social attractions. Some, if not all, of these deficiencies, are without remedy, and therefore, our tactic has been to look for other more creative solutions.

The National Health Service Corps program is one of the finest federal assistance projects emanating from Washington to date. It is our expectation that in mid-November, HEW will announce that Sioux City has been approved for the first "Urban Initiative" National Health Service Corps project in the United States. This opportunity for us is as a result of our critical shortage of family physicians in Sioux City. Because this is a prototype project, there appears to be innumerable possibilities for adaptation and modification in future years which would assist in the solving of rural health problems also. Specifically, we are referring to the

possibility that within a short period after the Sioux City medical office project is operational experiments with rural outreach can be developed. A few of the possibilities which come to mind include satellite offices in rural communities staffed by physician extenders, circuit riding, and others.

We feel that the key to the success of our Urban Initiative project, as well as any others that may extend into the rural areas around Sioux City will hinge in large measure on the ability of the federal government to work in partnership with private sponsoring institutions, such as St. Joseph Mercy Hospital. Because the problems experienced in specific localities vary one from another, the nature of the federal assistance should have flexibility for customization.

We hope that these comments will be helpful, and we look forward to the opportunity of participating in the field hearing scheduled in Merville on October 17.

Sincerely,

SISTER MARY MARGARET WESTRICK, R.S.M.,
Administrator.

WEBSTER, JORDAN, OLIVER & WALTERS,
Winterset, Iowa, October 19, 1976.

DEAR SENATOR CLARK: I have received your letter of October 7, 1976. If you are really interested in helping rural health care, there are a number of things that could be done.

First of all you could do away with the regional health planning councils and commissions. We happen to be in one with Des Moines and their attitude seems to be that we should close all our local hospitals, move our doctors to Des Moines and take care of all health care in Des Moines. I can't agree with that because I know as a practicing lawyer that a number of people are living in Madison County today because we have a local hospital and they would not be living here if they had to go to Des Moines for health care. Big is not necessarily good.

Secondly, Congress can exercise its responsibility of overseeing some of the ridiculous regulations that are being written. We recently had to spend in the neighborhood of \$100,000 on the Madison County Memorial Hospital in Winterset to put in a fire escape that will allow 200 people to exit in 3 minutes time. This is a 40-bed hospital that has never had 200 people in it since the day it was built and I fail to see the necessity of a fire escape that will exit more people than there are ever going to be in the hospital.

We are also in the process of spending 1.4 million dollars to remodel the hospital due to another set of ridiculous regulations. The government regulators have decreed that the kitchen ceilings in hospitals have to be 13 feet high. I don't think God ordained that hospital kitchen ceilings have to be 13 feet from the deck but it might as well be ordained by God because we have to do it or close the hospital.

Your hospital planners have further determined that all of our hospital rooms are one foot too narrow and therefore, all our hospital rooms have to be expanded by one foot at a great expense to the taxpayers and no increase in care to patients. I further understand that they are requiring toilets be placed in each hospital room and when 80% of our patients are on a bedpan, I fail to see the necessity of saddling the taxpayers of this county with the expense of installing a toilet in each room.

I could go on and on about the silly requirements we are faced with and most of them are just plain silly. We have had a good hospital here since the early 1950's that has provided excellent care for the patients. I have been hospitalized twice for surgery in the past 18 years and our last child was born in the hospital here in Winterset without the benefit of these ridiculous regulations.

Sincerely,

LEWIS H. JORDAN.

SHELDON, IOWA, October 18, 1976.

DEAR SENATOR CLARK: To further elaborate upon suggestions I wrote on the back of an envelope at your meeting at Merville yesterday, I have decided to send you this letter.

Too often chiropractic is left out of the total picture of health problems by members of the other professions. This is often done at the insistence of the AMA; yet many people rely upon chiropractic, chiropractors are licensed, and chiropractors are interested in the total health picture.

One of the complaints the medical group aims at chiropractors is that we don't refer patients to the MD's enough when medical care is indicated. On the other

hand very few patients are referred to by MD's when chiropractic care is indicated. I could easily state that I refer 100 cases to MD's for every 1 referred back—without fear of contradiction. However, this does lead us to a problem—that better diagnostic facilities be made available to the chiropractors, who could therefore give better care to the patient and possibly make referrals more often, if this is indicated. There are some problems that exist in Iowa that do not seem to exist in a number of states where I believe more progress has been made.

X-ray equipment, for instance, is becoming much more expensive. Some very good used equipment is rapidly on its way to being declared obsolete due in part to excessive federal regulation, such as that for automatic collimation. I have been told that new X-ray machines will cost at least twenty thousand dollars, and used machines will become almost impossible to buy. Think of the expense to a doctor just out of school for all of this expensive equipment. I have tried for 20 years in Spirit Lake and Sheldon to get hospitals to take X-rays for me to no avail. A few years ago I invested in a better X-ray machine to meet all existing regulations. When a request was made for me to help pay for a \$75,000 X-ray machine for the local hospital, naturally I refused.

The expense of lab equipment and hiring of trained personnel to run it is impractical for the individual doctor. Perhaps you are aware of the fact that at the present time, according to a legal ruling in Pella, that it is illegal for a chiropractor, or trained personnel, under a chiropractors supervision, to draw blood for diagnostic purposes. The modern chiropractor is trained to take advantage of such tests and they should be made available somehow.

1. In the interest of patients there should be more complete utilization of x-ray, laboratory and hospital equipment.

a. Make hospital x-ray and laboratory equipment available to all of the licensed healing professions. This can only be done by federal regulations which withhold funds unless hospitals cooperate. Not too often, but occasionally, I believe the chiropractor should have hospital facilities available for care of seriously ill patients who have great difficulty in driving to the office for treatment.

b. Encourage intra-professional clinics of MDs, osteopaths, chiropractors, dentists, optometrists, podiatrists and other specialists where equipment is available to the various doctors and consultation handy.

2. Legislative change in the Medicare program to put chiropractors on the same basis as MDs regarding x-rays. Let the chiropractor decide if x-rays are necessary. If they are, have a limit on how much can be charged but have it paid by Medicare.

3. Eliminate the mandatory "automatic collimation program" for x-ray machines. If certain doctors, hospitals, or clinics are found guilty of not using manual collimators properly then they could be required to use automatic collimation which is a very expensive and troublesome addition to x-ray equipment.

4. Ease up on the restrictions of the types of cases chiropractors can be paid for by Medicare. Chiropractors play a role in taking up the slack in the paramedical field. The restrictions placed by Medicare eliminate about 50% of the problems I have been taking care of routinely for 27 years and I'm sure this applies to most chiropractors. Whoever wrote these restrictions was not acquainted with chiropractic. In areas where a chiropractor practices without an MD, his scope of practice necessarily encompasses an even wider range.

Sincerely,

DR. EARL MARTIN.

ADAMS COUNTY PUBLIC HEALTH NURSING SERVICE,
Corning, Iowa, October 6, 1976.

DEAR SENATOR CLARK: I have read your letter of October 1, 1976, as well as the speech delivered before the Senate.

I am wondering what can be done to help the County Public Health Agencies? The Public Health Nurse covers many areas—from new-borne to the elderly—teaching, supervising, giving care, etc. It is this way many of these people are able to stay in their homes, thus not becoming a county ward or going to the nursing home.

Our county, Adams County, Iowa, is currently on the Shared Salary Program, which we are fortunate to be a part of. However, with rising costs, I'm concerned about the continuance of the program, especially in small counties, such as ours.

Prior to this fiscal year, we were on the 314D Grant Program for three years. This gave us a good opportunity to get established in the county. We would like

to see more monies allocated to aid the Public Health Nursing Agencies. At the present time we are in need of a second registered nurse and a Home Health Aide, The county is unable to find these.

Inclosed are statistics, for the past fiscal year, from Adams County, which may help to show the age groups that are served by our Public Health Nurse, and the related auxilliary duties connected with this service.

We are glad you see the need for rural health care and are supporting it.
Respectfully,

Mrs. ANN KING,
Public Health Nurse.

Iowa State Department of Health
DIVISION OF NURSING

PHN 108 1-1-70
CPA 12288 11/71

MONTHLY REPORT OF PUBLIC HEALTH NURSING

Name of Nurse Ann King Report for 1975-76
County Adams, Corning, Iowa

AGE GROUPS	I		II		III		IV		V		VI		TOTAL SERVICES	CARE OF THE SICK	HOME HEALTH AIDE SUPERVISIT
	1 YR.		1-4 YRS.		5-12 YRS.		20-44 YRS.		45-64 YRS.		65+ YRS.				
	adm	ser	adm	ser	adm	ser	adm	ser	adm	ser	adm	ser			
A- Antepartal															
B- Postpartal													3	3	
C- Tuberculosis															
D- Venereal Disease															
E- All Other Communicable Disease															
F- Dental															
G- Mentally Ill															
H- Mentally Retarded															
I- Vision												27	27		
J- Hearing															
K- General Health Supervision		7			1		7		53			340	406	2	
L- Arthritis												31	31		
M- Cancer												72	72		
N- Cardiovascular					6		17		164			1062	1070	179	
O- Diabetes									1			33	34		
P- Orthopedic									8			9	17		
Q- Other Chronic Illness (Specify)									56			23	77	2	
TOTAL		7			7		24		282			1600	1737	183	

In behalf of Long distance--51; In-calls--202; Out-calls--253.

Administration (specify) Includes conferences with other health and welfare groups, talks, classes attended, etc.

Conferences--Social services--96; Doctors--45; Auditor--16; Congregate Meals--37; OEO--1
Easter Seals--14; Out-County PHN's--17; Region V--15; HHA--62; Region IV--9; School--2;
Relief officer--7; Head-Start--7; Hospital--15. In-service--7. Board of Health--8.
Project Council--8.

Mileage--5226 miles for year July 1, 1975 to June 30, 1976.

Number of homes visited for the first time this year 116

Number of individuals given family planning information or service the first time this year 1

B/P CLINIC 1975-76 FISCAL YEAR REPORT

Date	Checked	New	Referred	Volunteers	Hours	County farm and sheltered W.
1975:						
July.....	86	15	20	7	21	48
August.....	112	25	29	7	21	55
September.....	113	30	40	7	21	
October.....	117	16	24	7	21	35
November.....	90	9	17	9	27	
December.....	82	8	14	9	27	49
1976:						
January.....	69	3	15	8	24	47
February.....	89	4	19	10	30	50
March.....	68	8	16	4	12	51
April.....	70	11	15	9	27	
May.....	107	10	19	9	27	52
June.....	94	13	20	11	33	47
Total.....	1,097	152	248	97	291	434

CITY OF OTTUMWA,
Ottumwa, Iowa, October 7, 1976.

DEAR SENATOR CLARK: Thank you for requesting my input on your search for new approaches to rural health care and what federal government can do to help.

I realize the federal government is pouring millions of dollars into local and county governments to help with their many and various problems. However, in spite of the fact that some of the guidelines have indicated that certain priorities should be given to local health and environmental health problems, it seems the money is pretty well spent or distributed by the time it gets to the local health departments. I guess it is typical of some individuals who never see a physician until they are ill. So it is with public health, it never gets any attention until a real serious problem breaks out. There never seems to be enough money to do the various health programs we would like to do to prevent these problems from happening. The following is an example of what I mean, at least at our local level in Ottumwa:

1. The need for an up-to-date building to house all public health related activities.
2. The need for more Public Health Nurses to call on the many people requiring attention in their homes, yet who do not feel they should see a doctor, and do more public clinics.
3. The need for more home health aids to assist the nurses in their daily activities.
4. The need for more sanitarians to help people with their housing, private water and sewer system problems, be involved with better rodent and insect control, implement better food establishment controls, etc.
5. The need for more money to attract and keep people in the above positions. (As an example, this administrator is considering seeking employment in a different profession or at least take on a second profession due to inadequate salary being paid.)
6. Last and probably most important, create some sort of an incentive for more family practitioners. It seems as though we have a trend toward specialization and away from family practice in the medical profession. This, I feel, leads to frustration, especially among the elderly, when they want medical help and do not know where to turn.

I guess what is needed is to have a person employed by the federal government as a liaison to local health departments to see what their needs are, and help provide direct finances to these people to implement the needed programs of the area. The reason I say this, is because so many times the problems of local health departments go unnoticed until there is a crisis, and I feel a crisis orientated government is a costly way to operate.

Once again, Senator Clark, I thank you for the opportunity of giving input to your endeavors to help in rural health problems. I know what I have hit upon is only a drop-in-the-bucket of the many complex problems that are involved in providing many much needed health services to the rural residents of Iowa. I do intend to be at one of the hearings you have planned if at all possible.

Sincerely,

GLENN C. JACKSON, R.S.,
Deputy Health Officer,
Ottumwa Health Department.

THE COOPERATIVE LEAGUE OF THE USA,
October 8, 1976.

DEAR SENATOR CLARK: In singling out this month possible new approaches to rural health care as the focus for your field hearings of the Senate Rural Development Subcommittee you are centering this effort on the demonstrably inadequate provision now being made for health protection in farm and small town areas in America's heartland. This holds special interest for and commands the warm support of the Cooperative League of the USA because so many of our members in farm supply and marketing cooperatives are concentrated in these areas and they are keenly conscious of the needs your Subcommittee will be investigating.

Attracting new professional manpower through wisely conceived federal programs, in our opinion, is the prime need and clearly indicated first step which, along with more comprehensive financing of rural health services, should do much to bring into better balance the attack on this growing problem for so much of rural America.

The community health centers being established in spotty fashion have made a promising beginning as we address this troublesome situation. But the withdrawal of minimum needed funding threatens to nip in the bud the effectiveness of such centers before their use gets well started.

We believe the conjunction of the two problems of inadequate rural health services and the problem of young people wanting to enter the medical profession facing financial difficulties offers an opportunity if the aid extended to them is linked with clear prior understanding that those who are assisted will commit themselves to begin their professional careers in rural America. If they do agree to accept help on this basis we owe it to them to provide the hospitals, clinics, and community centers now so sadly lacking.

Your hearings will do much to pinpoint where the need is and the exact nature of present deficiencies. Cooperatives stand high on the list of assets already present in rural America to provide the focus, leadership, and support your efforts will need if you are to succeed and we hope you will have this in mind as you undertake your survey. As you know, Iowa is already a flagship state in terms of numbers of cooperatives with strong leadership and the sense of community needs, and responsibilities which means they are geared to be a valuable factor in the effort to solve this major problem. October is Cooperative Month and its observance this year will have new significance if it is related to what your hearings are all about.

Sincerely,

SHELBY E. SOUTHARD,
Director of Public Affairs.

THE FAIRFIELD CLINIC,
Fairfield, Iowa, October 9, 1976.

DEAR SENATOR CLARK: Thank you for including me in an invitation for the hearings on Rural Health Care in Iowa. Unfortunately, the times and places of the hearings are such that I will be unable to attend any of the sessions, but I welcome the opportunity to express an opinion.

I was invited to Iowa by Coach Eddie Anderson in the late 40's but was told, when I was ready to enter Medical School, that I must go elsewhere because Iowa University could only train Iowans. So I went to Washington University in St. Louis, subsequently to the University of Minnesota but returned as a Resident at University Hospital in Iowa City. In the last 20 plus years I have been, by choice, a rural Iowa physician. The Group that I established in 1953 now cares for 10,000 of Jefferson County's 18,000 people. I guess I would qualify as one of the solutions to the rural health problem rather than one of the causes.

I look with interest on your statements in the Senate Congressional Record. Please—don't use rural health care as a club against Republicans or Democrats; and let's not have any more programs until the ones we have start working! If Medicare, Medicaid, Blue Cross-Blue Shield and the other private insurance plans were used to help recruit medical personnel to the rural areas, additional expensive programs would be unnecessary. Instead, they have been used to subsidize migration of rural physicians to the cities. Let me illustrate: if I remove a skin malignancy in Fairfield, the Blue Shield-Medicare allowance might be as much as 40% lower than if I did the same procedure in Des Moines. Medicaid cuts liberally also, but I don't have the same evidence for the differentials. At any rate, the health care planners seem to be telling me that if I would have taken my training and skill to Cedar Rapids or Des Moines, they would reward my move with money. Therefore, I could stop working an 80 to 100 hour week and settle

down to a comfortable 50 hour week. The refusal for those of us in our Group to go has been little short of sheer stubbornness, but I don't blame the young doctors who have come out in the last 10 years for filling up the cities. If you are really interested in getting health care back out into the country, why not impress on the present programs that there should be equality? If you are really interested in bringing health care to the rural areas, why not tilt the remuneration the other way? I almost smile to offer such a simple solution because I realize the election votes are all in the heavily populated medically covered areas. Thanks for listening.

Sincerely,

JAMES H. DUNLEVY, M.D.

DAVENPORT, IOWA, *October 8, 1976.*

DEAR SENATOR CLARK: I read with great interest your recent speech on rural health care.

You asked for my reactions and comments.

1. Medical schools state that they are not able to handle more students. Yet the present cost per student of medical training seems to be very high.

2. Our colleges and universities tend to be training nurses for administrative positions in hospitals rather than public health and clinic settings.

3. Training of both physicians and nurses should be expanded to include practical experience in clinic and rural settings.

4. Nurse practitioner programs need to be expanded for schools and clinics with certification granted for some.

5. Expand the training programs of dental hygienists to include exams for school and rural settings.

6. Medical personnel should be made more aware of existing problems and be less vulnerable for lawsuits.

7. Higher education should do more to meet the student and community needs, constant development of new programs, assessment of those in existence and have bi-annual conferences with those employed in positions outside hospital settings for evaluation.

I am sorry to be unable to attend the hearings you are conducting due to job commitment as a public school nurse.

However, I would be very happy to meet with you and discuss the problems further and thank you for the opportunity to express my ideas.

Sincerely,

MARJORIE V. ANDREWS, R.N.,
Davenport Community School District Nurse.

THE UNIVERSITY OF IOWA,
Iowa City, Iowa, October 21, 1976.

DEAR SENATOR CLARK: We have heard and read with great interest your position on rural health problems. Your support and apparent enthusiasm for the utilization of type A physician's assistants in these problem areas is certainly well received in this office.

I am enclosing information about this program and its graduates, which will be of interest to you; let me highlight certain points:

To date we have graduated 45 physician's assistants with B.S. Degrees conferred by the College of Medicine.

Thirty-two (71%) are currently employed in Iowa (refer to Table and map).

Each year we accept between 20 and 25 students to enter the two-year program. Please refer to Table 2 for a summary of the credentials of the previous five classes.

This program has scored among the top five programs in the country (out of 52 programs) on the National Certification Examination for Primary Care Physician's Assistants for the last two years.

We are proud of our program and the caliber of our graduates. We feel they will have increasing impact on rural health delivery systems, but only if appropriate legislation exists which allows for their optimal utilization. The position of the

Social Security Administration on third-party reimbursement for physician's assistants' services to Medicare patients is ridiculous. On the one hand the government budgets enormous sums of money for the initiation and continuation of physician's assistants training programs, and on the other severely restricts their utilization. This is of particular concern in Iowa which has a large elderly population. I think it criminal that these people are abandoned at a time when they should enjoy the fruits of their labor.

Thank you again for your timely support. Continue in your efforts.

Remaining sincerely,

DENIS R. OLIVER, Ph.D.,
Director, Physician's Assistant Program.

Enclosures.

TABLE 1.—UNIVERSITY OF IOWA, EMPLOYMENT: PHYSICIAN'S ASSISTANT PROGRAM, GRADUATES (1974-76)

Population	Class of 1974 (10)	Class of 1975 (17)	Class of 1976 (18)
State of Iowa:			
Less than 5,000.....	1	4	7
5,000 to 10,000.....	2	1	0
10,000 to 50,000.....	2	3	6
Greater than 50,000.....	1	4	1
Out of State:			
Less than 5,000.....	1	1	2
5,000 to 10,000.....	1	0	0
10,000 to 50,000.....	2	1	2
Greater than 50,000.....	0	0	0
Unemployed as a physician's assistant.....	1	3	0

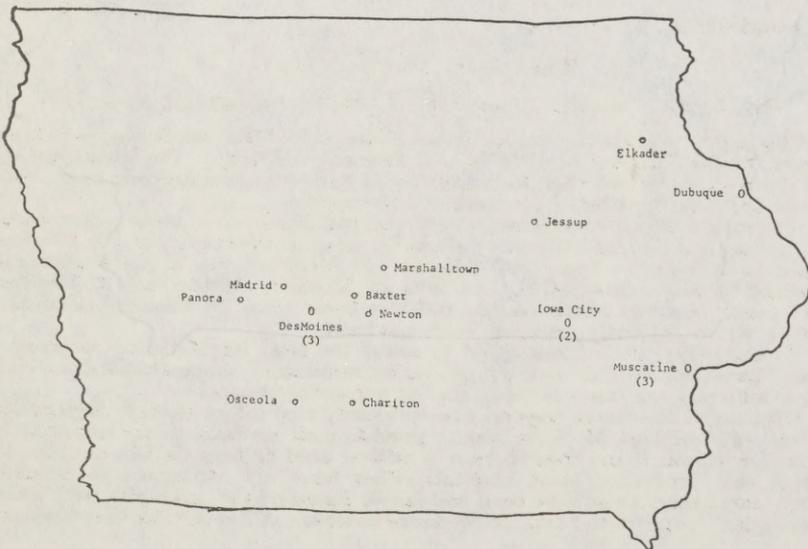
GEOGRAPHICAL DISTRIBUTION OF PHYSICIAN'S
ASSISTANTS: Iowa Graduates



TABLE 2.—COMPARATIVE SUMMARY OF PHYSICIAN'S ASSISTANT CLASS PROFILES FROM 1972 THROUGH 1976

[Figures in parentheses indicates percentage]

	Class of 1972-74	Class of 1973-75	Class of 1974-76	Class of 1975-77	Class of 1976-78
CLASS PROFILE					
Number in the class.....	10	20	20	26	22
Sex:					
Male.....	(50) 5	(70) 14	(70) 14	(65) 17	(50) 11
Female.....	(50) 5	(30) 6	(30) 6	(35) 9	(50) 11
Residency:					
Resident.....	(90) 9	(90) 18	(80) 16	(69) 18	(68) 15
Nonresident.....	(10) 1	(10) 2	(20) 4	(31) 8	(32) 7
Age.....	26.5	25.9	25.6	25.3	24.5
Range.....	21-35	22-36	20-43	21-31	19-31
EDUCATIONAL BACKGROUND					
Total college credits.....	144.8	133.1	128.8	124.4	124.0
Cumulative G.P.A. (A=4.0).....	2.93	2.92	2.78	2.98	3.11
Total science credits.....	51.8	50.1	54.8	43.8	55.0
Cumulative G.P.A.....	2.98	2.94	2.79	2.97	3.16
College degrees:					
A.A.....	0	0	1	1	1
B.A./B.S.....	5	10	14	19	17
M.A./M.S.....	1	3	1	1	2
None.....	4	7	4	4	2
HEALTH CARE EXPERIENCE					
Length.....	49.4	33.7	27.6	25.5	26.9
Categories:					
Nurse.....	2	0	0	0	1
Nurse's aide/assistant.....	2	5	2	5	7
Corpsman/medic.....	1	1	5	4	2
Orderly.....	4	5	6	5	2
Emergency medical technician.....	0	0	1	4	2
Medical technician.....	1	3	0	1	1
Surgical technician/X-ray technician.....	0	0	0	2	2
Allergy technician/inhalation therapist.....	0	2	1	0	1
Informal/volunteer.....	0	1	5	3	4
Laboratory research assistant.....	0	3	0	2	0

GEOGRAPHICAL DISTRIBUTION OF PHYSICIAN'S
ASSISTANTS: Non-Iowa Graduates

CASS COUNTY MEMORIAL HOSPITAL,
Atlantic, Iowa.

DEAR SENATOR CLARK: It is my understanding that the problem discussed at the hearing at Treynor and other places in Iowa is a lack of adequate medical coverage in certain areas. The solution that was discussed before the committee of evaluating the appropriateness and need for more benefit coverage for medical extendor services is sound in my opinion. I think there is another area which should be called to your attention.

There is a lack of and a great need for Medicare and Medicaid benefit coverage for home Respiratory care services. This coverage, although added expense for the program initially, would save the taxpayers money in the long run and increase physician availability to other services in rural areas. At Cass County Memorial Hospital, Atlantic, Iowa, there is a hospital-based home care program. We currently find that home or nursing home respiratory therapy services are not recognized by Medicare for reimbursement. Therefore, respiratory therapy services, which are important in preventing re-hospitalization of patients with chronic lung diseases, are denied because of economic barriers.

If this coverage would be available, home therapy instruction and on-going supervision could be done. This would insure that the people inflicted with respiratory ailments would be keeping in a better state of health, thus reducing hospital admissions and lengths of stay.

HOME CARE FOR RESPIRATORY DISEASES

Reasons for need

1. Doctor Fickle pointed out that a larger percentage of the general population is now 65 or older, compared to the past.

2. The occurrence of respiratory ailments (emphysema, bronchitis) have increased up to 300% or more in the last few years because of cigarette smoking and air pollution.

3. These diseases are a chronic condition observed more in older people. There is generally no cure, but these people can be maintained with proper therapy.

4. People affected have decreased mobility due to the nature of the disease.

5. Treatment and care are required on a daily basis. It is possible to teach the patient or family to administer these treatments.

6. Due to reasons 4 and 5, maintenance and treatment of these diseases takes place in either the home environment or the hospital.

7. As of now, there is no carryover of treatment to the home environment that is supervised.

8. The need for re-hospitalization of these people is very high without a home care program.

SIDNEY LEISE.

Attachments.

HOME CARE: MEDICARE SURVEY

(By Marilyn Farley, Respiratory Therapy. January/February 1975)

This article reports the results of the Home Care-Medicare Survey which appeared in the July/August 1974 issue of *Respiratory Therapy*. The survey focused on the question of whether Medicare should reimburse hospitals for home visits made to COLD patients by respiratory therapists.

Respiratory Therapy was motivated to undertake the survey for several reasons: 1) funding had been identified by various therapist as the major problem hospitals faced in initiating a home care program; 2) Medicare was a logical source of funding because so many COLD patients are Medicare eligibles; and 3) Medicare had been known to reimburse hospitals for home visits by therapists despite a policy which explicitly prohibits such payment.

Consequently, the editors hoped to assess the need for Medicare coverage of home care programs as seen by practicing respiratory therapists, and to learn how uniformly the law was being applied across the country.

RT learned that most respondents—primarily respiratory therapy department heads—do feel that Medicare should provide such coverage; more importantly, however, it was found that there is a critical need to help COLD patients via home care programs. Most hospitals either have not attempted to establish home care programs or have tried and failed. Based on the unanimity with which respondents support this type of Medicare coverage, RT concludes that financing

is the primary obstacle preventing the establishment of such coverage—all respondents were able to identify a patient population which could benefit from a home care program.

Survey findings suggest that discrepancies in Medicare payment policy are not widespread. Respondents unanimously state that Medicare does not reimburse their hospitals for home visits made by respiratory therapists. And, as already indicated, all agreed that Medicare should allow payment for such visits. Seventy-seven percent checked the "strongly agree" category; the remaining 23% checked "agree." No one "disagreed" or "strongly disagreed" that such coverage should be provided.

A footnote was added by John M. Dobbin, Technical Director of Respiratory Therapy at 421-bed Hialeah Hospital, Hialeah, Fla., who believes that not only Medicare but *other* third-party carriers—Blue Cross, for example—should be more willing to provide coverage for this kind of service and for outpatient rehabilitation clinics.

The related statement, "I urge Medicare officials and our nation's legislators to support an amendment to Social Security legislation to make such payment possible," also received full backing from respondents, who indicated that this coverage should be a high-priority item (65% "strongly agreed"; 36% "agreed").

A considerable degree of political sophistication must be developed, however, before such support will have much meaning. Therapists in Vermont and New Hampshire have already begun to learn that lesson. Reports respondent John Lehmus, Chief, Respiratory Therapy at 161-bed Putnam Memorial Hospital, Bennington, Vt.: "Within the past six months the Vermont and New Hampshire Society has tried in vain for a bill presented to the House of Representatives for reimbursement in nursing homes and in the patient's home. This was done through Rep. Emond from Brattleboro. The bill was held up in committee, and we don't feel it will ever come up again."

The article accompanying the survey—"The Medicare Roadblock"—pointed out that while money was available for Medicare demonstration projects, respiratory therapy was not a high-priority item. In determining whether an item should have priority, two criteria are generally employed: first, can people with "x" medical problem be taken care of in another way at less cost? For example, can hospital care be replaced by home care? What dollar savings will result? And second, do large numbers of patients need care for "x" medical problem, so that the volume of savings will be great?

In terms of sheer numbers of COLD patients, as reported in "The Medicare Roadblock," the potential savings to the taxpayer could be substantial. However, this survey attempted to get at these questions from the individual therapist's perspective. As a starting point, therapists were asked whether they thought funds should be made available for respiratory therapy home care demonstration projects. Again, the response was overwhelmingly favorable. (Sixty-four percent answered "strongly agree" and 36% answered "agree.")

The next question asked therapists whether they felt that their hospitals could use such funds effectively "in a project intended to demonstrate a savings potential to the Medicare program." (The survey purposely avoided addressing the question of actual savings which might result from a home care program, since it was recognized that a dollar figure would only be speculative until a study had actually been conducted and evaluated.) While 68% felt they could use such funds well, 10% said they could not use the funds well and another 22% had no opinion on the matter.

Probably the most startling finding in regard to demonstration funds, however, was that a full 86% of the respondents expressed a desire to receive information on how to apply for such monies. On the one hand, RT noted that there was interest in the specifics of acquiring such funds; on the other hand, RT was disturbed that respondents—many of whom had administrative responsibility for their departments—did not even know how to apply for such funds at this late date (the relevant law, in this case, was passed in 1972).

True, as RT learned in researching "The Medicare Roadblock," tracking down sources of federal funding can be as frustrating as searching for the fountain of youth. Nevertheless, the acquisition of these funds—funds which do indeed exist—is, or should be, of vital interest to respiratory therapy administrators attempting to offer high-quality patient care.

The first step, as Michael De Angelus, Technical Director of Respiratory Therapy at 180-bed Augusta General Hospital, Augusta, Me., found, was to work with local Medicare personnel. He made contact with them and is currently receiving excellent cooperation in developing a demonstration project.

At this stage, he notes, "We have drafted an experimental project proposal for hospital fee-for-service reimbursement. The program would be based at the hospital and would use a regional health agency as a certified billing intermediary. Presently, home care is provided via a service company which is unable to provide the standard of care patients need. We are hoping our project will be funded so that the focus will be on patient care rather than rental of equipment as it is now."

Of particular note in these responses is one salient fact: although respondents unanimously supported allocation of demonstration funds to respiratory home care projects, many didn't want information on such funds; nor do they think they could use the funds well in all cases. The editors concluded that respondents recognize the need to fund such projects, but are not concerned whether they, and their hospital specifically, might benefit.

Finally, respondents were asked to estimate how many patients could benefit from home visits made by therapists in a given year. This question was posed because RT believed that department heads were in a position to estimate the number of potential beneficiaries without first having to carry out an exhaustive study.

In this case, therapists indicated that anywhere from three or four to as many as 250 patients could benefit from an RT home care program in a year. Responses came from hospitals in 18 states; facilities ranged in size from 48 to 600 beds, and were situated in urban, medium-sized, small and rural communities. In interpreting the data, the editors came up with a hypothetical hospital size and the RT home care caseload it might be expected to have. We estimate that in a 222-bed facility, between 50 and 61 COLD patients might participate in a home care program in a given year. We arrived at these figures by 1) dividing the number of hospital beds by the number of hospitals in the survey, and 2) dividing the number of patients who might be served (minimum and maximum) by the number of hospitals in the survey.

CRITICAL NEED

Ninety percent answered that there is a critical need to make home therapy treatment available to patients; only 5% think treatment could be equally effective in another setting. Another 5% indicated that either a home or other treatment locale would be appropriate, depending upon the situation.

In total, therapists gave eight basic answers to the question, "Why is there a critical need to help these people at home?" The most frequent comment (35%) was that these patients needed supervision (and/or training) by a respiratory therapist in order to properly care for themselves at home. A close second was that home care would reduce the need for (re)hospitalization (32%). Other reasons mentioned include: that home care would lower costs; that it would shorten subsequent hospital stays; and that it would result in healthier patients (7% each). Home care was also felt to be important because patients have transportation problems, don't see a physician regularly, and need help in adjusting to family situations (4% each).

Why the critical need? "These people are being sent home with little or no help at all," laments Craig W. Megargee, Technical Director, Cardio-Pulmonary Service at 360-bed Burlington County Memorial Hospital, Mt. Holly, N.J. In a similar vein, John Lehmus at Putnam Memorial Hospital remarks, "Home care could keep these patients out of the hospital."

Eileen M. Fusco, Supervisor of Respiratory Therapy at 240-bed Syosset Hospital, Syosset, N.Y., comments, "Most people are hospitalized just to receive IPPB. And if they are treated at home, they are not supervised in the use of their own equipment."

Agrees Ann Amodio, Director of Respiratory Therapy at 85-bed Mercy Memorial Hospital, Urbana, Ohio, "Patients have no training in using and cleaning their equipment. Neither do they have instruction about their medication and breathing."

The related problems of training and supervision are also emphasized by Michael J. Cestone, Chief Respiratory Therapist at 450-bed Memorial Hospital of Dupage County, Elmhurst, Ill., who notes, "Many home patients do not see physicians for long periods of time. They often do not clean their equipment properly and, after a while, may forget exactly how to give themselves a treatment for maximum benefit."

Florence L. Shunney, RN, Chief Respiratory Therapist at 225-bed Sturdy Memorial Hospital, Attleboro, Mass., sees a need for therapists to be in the home because "... the vocational nurses association, private vendors, etc., are only capable of taking care of nursing and mechanical problems." In a letter

attached to the survey form, she adds, "Since I filled out your survey, I have found that vendors give very little, if any, mechanical support (repair of machines) to the patient."

Opines Jerry Markle, Director, Respiratory Therapy and Cardiopulmonary Departments at 150-bed Memorial Hospital, Colorado Springs, Colo., "With COLD patients, home care reduces reinfection and, therefore, frequent hospitalization. It would allow patients recovering from respiratory infections and debilitating surgery to recover at home and would therefore lower hospital costs."

Some statistical information is offered by David E. Dillman, Evening Shift Supervisor at 500-bed St. Luke's Hospital, St. Louis, Mo., who notes, "The average COLD patient suffers an average of three or four 18-day hospital stays in a year due to recurrent infection." Proper supervision at home could eliminate this reinfection, states Dennis Forsberg, Director of the Respiratory Therapy and Pulmonary Function Lab at 290-bed Bethesda Lutheran Medical Center, St. Paul, Minn.

Robert J. Kieliszewski, Technical Director of the Respiratory Therapy Dept. at 140-bed Alpena General Hospital, Alpena, Mich., would like to see reimbursement for home visits by therapists because ". . . we are in northern Michigan and have no close manufacturers' reps who can act as troubleshooters when home patients need assistance."

Ron F. Metzger, Arkansas Area Manager, ITS Inc., at 48-bed Lawrence Memorial Hospital, Walnut Ridge, Ark., favors reimbursement for home care because ". . . we serve a poor income area where a lot of patients are on welfare or have small pensions, etc."

OUTPATIENT VISITS

While therapists think Medicare should reimburse hospitals for home visits by RTs, and while they feel there is a critical need to help home patients, 29% still believe that outpatient visits have equal merit. This finding suggests that therapists support the option of Medicare coverage for home visits, even though they might not go that route in their own hospitals. This is to say that a "feather-your-own-nest" attitude is not being exhibited.

Generally, however, outpatient visits were not widely viewed as a good alternative to home care. Sixty-two percent say that patients could not be equally serviced by outpatient visits. The remaining 9% view both home and outpatient care as acceptable, depending on the case.

Outpatient visits are opposed for seven basic reasons. The major objection therapists report relates to transportation difficulties (36%). A combination of poor health and age factors is identified in 18% of the cases. In another 18%, therapists state that the home setting is superior to an outpatient environment. Costs involved in outpatient care and the problems involved in obtaining treatments when they are needed were both named (9% each). Increased chance of infection and staffing were also mentioned (5% each).

Michael C. Coppens, Chief of Respiratory Therapy at 60-bed Calumet Memorial Hospital, Chilton, Wis., nixes outpatient care because of ". . . transportation problems due to the rural service area."

Responds Ron Metzger of the Walnut Ridge, Ark., hospital: "Outpatient care? Not with our foul weather conditions and poor roads during the winter months. Most patients must travel from 5 to 30 miles to the nearest hospital." Similarly, Jerry Markle of Memorial Hospital in Colorado Springs relates, "When our winters are severe (snow and low temperature), it is sometimes impossible for patients to travel. There's also the increased possibility of infection in going to an outpatient clinic and the fact that bedridden patients can't get to the hospital anyway."

According to La Mar L. Wyse, Director of the Cardio-Pulmonary Dept. at 156-bed Riverview Hospital, Noblesville, Ind., "Some patients are unable to get to the hospital when a treatment is needed. Besides, the patient is more relaxed, and therefore treatment is more effective, in the informal and natural home setting." David Dillman of St. Luke's Hospital in St. Louis seconds that thought: "The training for an at-home procedure should be given in the context of the home, where the procedure will be practiced."

Hospital-based home care programs have never been initiated or have been abandoned, some therapists report, for four basic reasons. The primary cause, not surprisingly, is lack of funds (67%). Inadequate staffing, lack of referrals by MDs and legal problems are also cited (11% each). Dillman summarizes the reasons his hospital has no home care program: "Lack of funds . . . lack of referrals by physicians . . . disagreement on legal responsibilities." Comments

Christa M. Hoeck-Petrie, Senior Respiratory Therapist at 600-bed Rancho Los Amigos Hospital, Downey, Calif., "We have not initiated such a program because of lack of staffing, which boils down to a lack of money."

HOME VISITS RARE

A few therapists report that their hospitals are involved, in one way or another, with home care programs. Yet therapists rarely make home visits, and when they do, they often are not paid for their time and services. None of the programs outlined by respondents would be full-fledged hospital-based home care programs for respiratory patients as described by Kaye Brady in "Starting a Home Care Program" (*Respiratory Therapy*, Jan/Feb 1974).

One kind of set-up and its benefits are explained by Tim J. Good, Director of Respiratory Therapy at Mount St. Mary Hospital, Nelsonville, Ohio, and Hocking Valley Community Hospital, Logan, Ohio. He notes, "We are presently providing home respiratory care for 75 or more people a year by the use of a private company in cooperation with an accredited home health agency. Most of the patients we serve have long histories of COLD and multiple admissions to the hospital. The Director of RT functions as an independent contractor for patients who need home care, and the home health agency provides follow-up nursing care."

The benefits? "Home use of IPPB, O₂, etc., has decreased the need for frequent hospitalizations. We feel hospital costs have decreased." The drawbacks, from Good's vantage point: "There's no money available for reimbursement for RT follow-up."

Sturdy Memorial Hospital, Attleboro, Mass., runs an unofficial program. Therapists train patients in how to use home equipment while they are still in the hospital, says Florence Shunney. Then, privately, therapists occasionally visit patients at home. "The benefits are great in the beginning," she opines, "but without scheduled visits, everything starts going downhill. The problem is financing. It's true that home care costs are high in the beginning, but they are certainly less than a hospital stay."

Home care is apparently a small-scale, informal service at 75-bed Hillsboro Hospital, Hillsboro, Ill., as well. "Home care is provided at the discretion of the respiratory therapy department," comments D. Holmes. "I would say that only two or three people are actually seen in their homes in a year. The problem arises in working out time to free staff members to go into homes because we are faced with a shortage of personnel. Also, therapists are on their own. While the department has a set charge for a home visit, if the patient is unable to pay, then the staff member is just out. That person may not break even."

About 30 patients a year are trained to do their own therapy at home while they are still in Putnam Memorial Hospital, says Lehmus, but he doesn't feel that this training effort constitutes a home care program. Further contact, Lehmus notes, "is limited to untrained salesmen who do not visit patients regularly."

Henry County General Hospital (a 166-bed facility in Paris, Tenn.) has initiated a home care program. Still, therapists don't go into the home "... except for some few nonreimbursed humane visits," according to George Turman, Chief Respiratory Therapist.

He tells *RT*, "We are a small hospital, far removed from the large medical centers, and minus most of the sophisticated equipment that is needed to establish a good, well-rounded pulmonary home care program. . . . [But] we have a home program, established about 10 months ago, which, despite its limitations, has been a tremendous success. Patient response has been the most gratifying aspect of the program. Some patients have been able to become much more active. All have required less frequent hospitalization and shorter stays. The savings to Medicare have been tremendous."

"I'm sure it would boggle the bureaucratic mind and create some gastrointestinal problems to consider a program that would help more people and at the same time save the taxpayer millions (and I think millions is a very reasonable estimate) of dollars. . . ."

"Very briefly, our program consists of education of the patient to his problem, provision of a home IPPB unit and usually alternating bronchodilators plus training in breathing, coughing, pulmonary toiletry, etc., and urging him to keep up with the program. As rudimentary as it is, we are helping a number of persons in the surrounding community. The total cost to patient or carrier is usually between \$150 and \$200, including the first supply of medicines. Both frequency

of admissions and length of stay have been decreased by at least 50%. I have not attempted to compute this on a dollar basis, but I think it is obvious that it is saving 'a whole bunch of money' and the patients are much better." (For full text of his letter, see *Postage Paid*, P. 72.)

A program which does include home visits by trained medical personnel (although not routinely by the therapist) has been established by Burlington County Memorial Hospital, reports Craig Megargee. Money comes from three sources: the Delaware Raritan Lung Assn., the Greater Delaware Valley Regional Medical Program and the New Jersey Regional Medical Program. A nurse-coordinator and a nurse-home care worker are on the payroll. (The program has been funded for only one year: Consequently, new funds, probably from the local lung association and the public health department, will have to be solicited in the future, Megargee says.)

Why was the program funded? "We had problems because I was having to visit patients to get them set up at home every five minutes, even though Medicare doesn't reimburse us for this service. It got pretty tiring, because we had quite a few patients out there.

"The American Lung Assn., through the Delaware Raritan Lung Assn., also realized that someone should be looking at these patients after they get home. So a volunteer on our administrative staff (a student in health administration) was asked to do a feasibility study, which he carried out with the help of three senior medical students at Rutgers Medical School. They visited these patients at home and took their histories (how often they'd been admitted, etc.). The study suggested that a home care program would cut down on readmissions and that 50 to 100 patients could benefit immediately. On the basis of this study, we were able to get funding.

"I think it's too early yet for us to really say anything about costs. However, the program has been quite costly. We've spent \$50,000 to \$60,000 so far and only have 15 patients. I think everybody is looking to see if the program is worth the expense. We may be putting out too much money." Patients are evaluated by a physician before being placed on the home care program and then are seen once or twice weekly for the first month and as needed thereafter.

Megargee prefers to have a nurse rather than a respiratory therapist go into the home. One reason is a shortage of trained therapists in his area. "We're in the sticks," he explains. "Most head towards the big city—either Camden, N.J., or Philadelphia." More important to Megargee is the fact that a nurse has broader training. "She evaluates the patient, makes sure he takes the medication and supervises his diet, and can discuss finances with him. Our nurse was trained by our department and then was briefed by Social Services, Physical Therapy and the Public Nursing departments as well.

"I still end up going into the home. Initial equipment setup and training is left to this department. Or I may end up making a visit to bail people out of trouble. I make calls three or four times a month on my own. It is either a volunteer effort or, sometimes, if the patient is in trouble, the Lung Assn. will help foot the bill."

Response to *RT's* Home Care-Medicare Survey certainly suggests that some therapists see a need for home care programs and for reimbursement of hospitals by Medicare when their therapists make home visits.

But as John Lehmus so poignantly asks, "What can we do?" still remains the thorny question. The solution is relatively easy to state. It is harder to implement. What is required is to document the case for coverage and push for changes in the law—or look for alternative means of funding home care programs (as Megargee has done). Readers are invited to write *Respiratory Therapy* to continue the exchange of ideas on this subject.

RT, meanwhile, has followed through with its promise to help stimulate revision of the Medicare law by communicating with appropriate government officials. Copies of completed questionnaires, the original article, "The Medicare Roadblock," and this article have been forwarded to the following: President Gerald Ford, Senators Edmund Muskie and Frank Church (who expressed support for home care programs in the preface to *Home Health Services in the United States: A Report to the Special Committee on Aging*) and Representative Paul R. Rogers, Chairman, Subcommittee on Public Health and Environment (of the House Committee on Interstate and Foreign Commerce). The same material has also been sent to Thomas M. Tierney, Director Bureau of Health Insurance, Social Security Administration, Department of Health, Education and Welfare, Social Security Building, Room 700 East, 6401 Security Blvd., Baltimore, Md. 21235; and Dr. Gerald Rosenthal, Director, Bureau of Health Services Research, Public

Health Service, Department of Health, Education and Welfare, Room 15-05, 5600 Fishers Lane, Rockville, Md. 20852. (Dr. Rosenthal is in charge of demonstration projects under Section 222 of Public Law 92-603.)

A HOSPITAL-BASED HOME RESPIRATORY CARE PROGRAM

(By James S. Allen ARRT, Respiratory Care, November 1974)

Home care was the original form of medical care, as hospitals did not always exist. Even when hospitals first appeared, they were correctly regarded as "death houses," and a patient preferred to remain in his home. In this report, however, we use the term "home care" to mean in general the continuing care, in his home, of a patient who has been treated for acute illness in a hospital. The care is ordered by a physician, and it may include medical attention; nursing, social service, and various kinds of therapy, including physical and respiratory therapy.

The home care concept is not new. In Boston in 1796, it was considered, from the welfare point of view, that the poor had the right to the dignity of staying in their homes rather than being hospitalized. The idea became more popular and hospital-connected in 1946 when a program was begun by Montefiore Hospital in New York City. After that successful adventure, home care became "an extension of the hospital without walls," the idea being that a 400-bed hospital with 50 home care patients became a 450-bed hospital.

By 1966, about 100 fully recognized programs were operating from American hospitals, with a big impetus coming that year from Medicare, which included a home health benefit. Since then, rising interest in health care delivery by consumers and the government has led most hospitals to examine new methods of delivering services, with home care receiving a lot of attention. It has finally been realized that the hospital's community responsibility doesn't start and stop at the front door.

When Medicare entered the home care picture in 1966, a home health agency could be certified for Medicare reimbursement only if it provided skilled nursing care plus another therapeutic service, such as physical therapy or speech therapy. Unfortunately, respiratory was not on the list of recognized services and could not be financed in this way.

NEED FOR RESPIRATORY HOME CARE IN TUCSON

The population of Tucson has a high incidence of cardiopulmonary disease among its 400,000 residents because the warm, dry climate has attracted many persons with these problems. Yet in 1970 when the Respiratory Therapy Service at St. Joseph's Hospital in Tucson began to examine the respiratory therapy home care in the area, we found that no agency was providing this care.

We surveyed the situation because we had received numerous requests to teach and assist patients who had breathing machines and breathing problems at home. All the local medical supply companies did was have their truck drivers set the equipment up. Every request we received was for someone with a breathing machine, so the care was mechanically oriented.

We found that many patients were frequently hospitalized, not because this was medically necessary, but because it was the only way their insurance would pay for the care.

We found that patients who remained at home often had difficulty getting to hospitals for outpatient service because of distance and lack of adequate public transportation. The financial drain of frequent inpatient hospital care also prevented others from purchasing expensive outpatient or home care.

After release from the hospital, patients received little and inadequate follow-up care and treatment. Instruction and information about therapy techniques given for home care was extremely unsatisfactory. They did not know how to use equipment or how to prepare and preserve medication, and the equipment was faulty and filthy; in many instances, it wasn't used at all.

Psychological, social, and educational difficulties were created by the heavy financial burden, the embarrassment many patients feel when in public, the requirement for extensive care and attention by relatives, and the lack of understanding and teaching about medical problems.

As a stopgap, the Respiratory Therapy Service did what it could, with some of our technicians making evening calls on their own time, without pay. But it was a hit-or-miss method, poor at best.

PILOT HOME RESPIRATORY CARE PROGRAM

We proposed to the hospital administration the undertaking of a six-month pilot home care program with the following objectives:

1. Provide continued therapy, proper instruction, and supervision.
2. Aim to decrease hospital care costs by decreasing number of admissions and/ or length of hospital stay.
3. Provide an alternative to the inadequate outpatient treatment facilities available at that time.
4. Evaluate the pilot program to determine whether it should be made a regular service.

The administration approved the pilot program with these stipulations:

1. That direct expenses for staff be paid from revenues of the program.
2. That no more than 30 patients be included in the pilot phase.
3. That the staff provide its own transportation with reimbursement of 10 cents per mile.
4. That the service be available only during weekday hours.
5. That only patients from our own hospital would be served.

We embarked on the pilot program, using the part-time services of a technician with a special interest in pulmonary rehabilitation. At the end of the six-month period, analysis of the experience showed the following:

We analyzed 30 patients, cared for more than 50, and had requests to care for 108. The average patient received two visits, each lasting an average hour and a half. Travel time for the average visit was 20 minutes. Travel during the program totaled 1,900 miles.

The patients ranged in age from 7 to 81 years, and 20 different physicians served 30 patients. The primary diagnoses were emphysema, bronchitis, asthma, bronchiectasis, and congestive heart failure.

Patients were charged \$25.00 for the first visit and \$10.00 per visit thereafter. Our cost averaged \$7.39 per visit. The collection rate was 100 percent.

As part of the Home Care Program we established a Better Breathing Club, which had as its purpose the educational, psychological, and social aspects of the patients and their families' needs. The Better Breathing Club met monthly for a two-hour session and had nearly perfect attendance.

THE PERMANENT PROGRAM

The Home Care Program had generated an abundance of publicity and as a result, funds were donated to purchase two cars, a treadmill, blood gas apparatus, and two portable, waterless spirometers. In addition, the patient and physician response was sufficiently encouraging to continue the program on a permanent basis. Another respiratory therapist was added to the staff to make two full-time staff with secretarial support.

The previous regulations were modified to accept patients of any hospital medical staff member whether or not they had ever been hospitalized at our facility. Charges for services remained unchanged, although costs now average \$11.00 per visit.

If the patient is hospitalized, early contact is made with the physician to determine his post-hospital needs. The prescription of "Home Care Program" is requested so the therapist can discuss home care with the patient and his family and observe the home environment. With this information, the physician and therapist together plan the program of home care and institute the measures while the patient is still hospitalized. The history and physical examination report, cardiac and pulmonary function studies, treadmill exercise tolerance, and blood gas analysis become part of the pre-home care regimen and patient record.

If the patient is not hospitalized, the same prescription is requested so the therapist can visit and observe the home environment. Baseline tests as directed by the physician are accomplished. This information and the physical examination and history are discussed with the physician to arrive at the care program which is to begin in the patient's home.

Home care may include intermittent positive pressure breathing, ultrasonic nebulizer aerosol therapy, compressed air aerosol therapy, bronchial drainage, breathing retraining and progressive ambulatory exercising and controlled oxygen therapy. Serial spirometric studies and physical examination are used to measure progress or make care regimen modifications. When possible, family members are included in the therapy sessions so they can better understand and can assist the patient with his needs.

Preparation and administration of medications, equipment maintenance and decontamination, monitoring of pulse rates and sputum samples are constantly emphasized and reinforced, both orally and with handout material prepared specifically for this purpose. Emphasis is on nonmechanical therapy.

A progress-reporting system which requires physician review and prescription renewal is carried out monthly. Each home care therapist is approved to take physician orders, so immediate needs are handled over the phone.

Other hospital personnel are used as resources. These may include, depending on patient need, a social worker, pharmacist, dietitian, speech therapist, physical therapist, and business office staff. Community resources such as vocational rehabilitation services are used frequently.

The Better Breathing Club meets monthly, with programs of educational nature followed by social affairs. Special programs such as swim parties are given for those under 16 years of age. A physical therapist assists in the organized, yet individualized, exercise programs at these events.

RESULTS

With our limited resources, we studied 44 patients over a 29-month period. These patients were the first 44 to be on home care the full 29 months. The following information was discovered:

1. In the year prior to going on home care, these 44 patients were admitted into our hospital 151 times. No record was obtained of their admissions to other area hospitals although we know this occurred.

2. For the 29-month period after going on home care, they were hospitalized a total of 93 times.

3. Previous hospitalizations were for an average of 17 days; after home care, the average was 15 days.

4. All 44 patients continued in their activities whether working, attending school, or keeping house. No reduction was found in measured pulmonary function of any patient when compared with the baseline tests. In the 29-month period, 659 patients age 20 days to 97 years were treated, and 1,522 home visits were made. Because they declined to continue, expired, or moved from the area, 103 patients were discharged from the program.

CONCLUSIONS

Home care is a feasible program for hospitals to provide in meeting their community responsibilities. Patients can receive as high quality of care as they would if they were hospitalized but at a considerable financial savings. In the 44-patient study, the decrease of two days per hospitalization for each patient would be an \$8,800 savings based on an average \$100.00 per day hospitalization. Even when admitted, none of these patients required intensive care. The program does help improve the patient's and family's understanding of the medical problem and therefore their ability to cope with it. The hospital-based home care program stimulated a local service company to start its own fully staffed home care service, with which we have excellent rapport. Inclusion of respiratory therapy as a benefit by third party payers will enhance use of this type of care by patients and make it a more reasonable financial risk for hospitals to undertake. Our home care program was successful enough to promote the formation of a licensed home health agency by the hospital which will include respiratory care, physical therapy, speech therapy, nursing care, and other health services. This should improve the chances for Medicare reimbursement.

HOME HEALTH CARE CLASS DECEMBER 5, 1974

I. Home Respiratory Care:

- (a) Home care in general.
- (b) Importance of observation of the respiratory patient.

II. Diseases:

- (a) Emphysema.
- (b) Asthma.

III. Slide presentation on filthy respiratory equipment.

IV. Demonstration of how to clean home respiratory equipment.

V. Oxygen Safety.

IOWA COUNTY PUBLIC HEALTH NURSING SERVICE,
Conroy, Iowa, October 8, 1976.

DEAR SENATOR CLARK: Thank you for your interest in health services for rural areas in Iowa such as Iowa County.

We are endeavoring to meet the needs which at times seems overwhelming. During July, August, and September 246 home visits were made plus 105 office visits. It took 27 hours overtime to keep up with the office work that needed to be done in that 3-month period. Besides the above statistics there were 59 visits I scheduled to make but did not have the time. This work could be expanded into other areas such as follow up from our Well Child Clinics and more follow up for stroke victims.

I feel funds should be pliable so when case load was down we could cut back on hours and use more when case load increased.

Thank you.
 Sincerely,

BEVERLY COX, R.N.,
Iowa County Public Health Nurse.

PUBLIC HEALTH NURSING SERVICE,
 CERRO GORDO COUNTY,
Mason City, Iowa, October 12, 1976.

DEAR SENATOR CLARK: I was very happy to receive your letter and really wanted to talk to you in person but the distance in the localities that you will be visiting are too far from Mason City, and I imagine this is because they are more rural areas so I will try to write in a letter part of what I would like to say to you. Am glad to see you are concerned as I am also and hope if you ever get closer to Mason City where I am located that you will call and I would hope to meet you in person.

Your proposal concerning health care to elderly is great but I wish to put in my two cents worth for Public Health Nurses. I have a sister in the Air Force and she is a nurse practitioner and I am aware of her greater education and experience compared to me but I have my BSN plus almost thirty years of nursing experience in every field and most recently did supervision at Mercy Hospital and kept this job up part time on weekends until last year.

My point is please not to overlook the PHN and the job that we do in the community. It would take a lot of money to educate a nurse practitioner and we have no guarantee that they will stay in our rural areas where by we live here and most likely will stay here.

Two years ago Mr. Butz and Mr. Winberg tried to cut the budget by cutting 214d funds and this was federal or state money to fund PHN salaries and naturally many small counties can not take over the salary of PHN so my point is that for better service sooner I would like to see more money funded to either keep or hire more PHN's.

We are allowed to do every skilled nursing procedure in the home that is done in the hospital except to administer intravenous medications and I would like to cite a few instances where we do save money in home care to more than off set salaries. With the help of families and health aids we keep a patient in his home for a long time where it would be costing up to a hundred dollars a day in the hospital.

Also, we go in the home and draw blood tests and take them to a hospital for results—for instance a man from Plymouth, Iowa that didn't know of our services would have to be transferred per ambulance to the doctor's office or hospital to have this blood and taken home per ambulance whereby we get the order from Physician, we get the necessary tubes and on a home visit can do the same procedure and I imagine that being taken per ambulance must cost Medicare around one hundred dollars plus discomfort to the patients—I hope you can understand my point and my request to use right now what is available and that is the PHN.

We do visit and do a lot of skilled nursing care and as our agency is certified we are reimbursed by Medicare if the patient meets standards.

My only complaint is the definition of homebound by Medicare—a homebound patient is one who is essentially confined to a place of residence due to an illness or injury and if ambulatory or otherwise mobile, is unable to be absent from his residence except on an infrequent basis or for periods of relatively short duration e.g. for a short walk prescribed as therapeutic exercise."

Now we do the skilled nursing and as I am paid partly by 214d funds and the rest of my salary by the county and am not pushed for funds, so we can do the nursing and we apply to Medicare and if they don't meet the requirements of Medicare we do not have to push to collect and we tell people that their tax money is applying for this service, but Medicare sends them a letter saying they did not meet requirements and the nursing visits will not be paid for and this hurts their dignity, and I do not consider it necessary. Now if they go to a doctors office the visit is paid and we can for instance take a weekly blood pressure and chart it and confer with the doctor, but they don't want to pay the PHN so you sound like a fighter and the first one that has expressed an interest, so I just want to say "good for you". We appreciate what you are doing and I think it is a priority and hope you can understand this letter and maybe I will get a chance to talk to you in person as I have been in public health for over eight years and think we play a more important role than we are given credit for.

I live in Clear Lake, Iowa and we do not just work 8-4 Monday thru Friday but are subject to call which could be at nine o'clock Sunday eve. and we do provide the service.

We give two daily insulins at the County Home 365 days a year where there is no R.N. and the care there is only about two hundred dollars a month with our services compare to \$800 or more if they have to be put in a nursing home for skilled nursing which would happen if we didn't visit 365 days a year. Both of these patients are happy and settled in a County Home and would be very unhappy if they were put in a nursing home and the expenditure of money is not necessary. Could go on and on with examples but if you even read this I am proud of you and hope to have further correspondence.

Sincerely,

MARY K. CAVANAUGH. R.N.

MADRID, IOWA, *October 12, 1976.*

DEAR SENATOR CLARK: I am a citizen of a rural community, and because I work, am unable to attend your series of senate hearings concerning health care in rural communities. However, since I feel very strongly concerning this subject, I feel compelled to write and express my views so that you may have the same of record in your files concerning this matter.

My family regularly employs the services of a P.A. for our family health needs. Because of the distance between our community and neighboring cities (where regular physician services are available), we feel we receive superior health care from a P.A. than we would from a specialist anywhere else. For example, our baby was sick last week. Within 5 minutes, the P.A. was in our home, examined the baby, and called the pharmacy for a prescription. We are grateful to pay for such services—had we taken the baby to a doctor elsewhere, it would have been hours before his medication would have been started. And—the situation might have been a life-or-death instance, which, fortunately, this instance was not.

Surely those patients whose health care is paid for by the government should be entitled to as much. A doctor wouldn't locate in our city—too many large cities nearby attract doctors with financial and medical facility benefits which our town cannot offer. To force a P.A. to work directly under the supervision of a doctor's physical presence would be to remove this valuable service from our community.

Again, I believe patients who are dependent upon government assistance to pay for their medical care are entitled to the same superior care which other citizens can avail themselves of—I am *not* saying that the government should pay for inferior quality care, because I do not believe that is the alternative.

There are numerous other instances where a P.A. in our community has been invaluable to us. One man, in gratitude for services rendered an ailing neighbor, donated a 4-wheel drive vehicle to our P.A. for making winter house calls. Our volunteer fire department receives one-a-month training from the P.A., and has gained the reputation of being the best rescue unit in the area (including some of the units in cities such as Boone, Ames, or Des Moines!). Citizens support these efforts, and the city recently purchased "beeper" units to assist the P.A. and the rescue workers in their excellent work.

Any assistance your committee can render our area in making direct payment to P.A.'s a reality, or in encouraging this area of the medical health program will be greatly appreciated by this taxpayer, and, I believe, my community.

Sincerely,

(Mrs.) PATRICIA A. CRONK.

BROADLAWNS,
POLK COUNTY HOSPITAL,
Des Moines, Iowa, October 13, 1976.

DEAR SENATOR CLARK: I followed with interest your recent hearings on health care and was pleased to receive your News Column for October 11-25. Your concerns are well justified and I know you are aware that solutions are more easily proposed than carried to fulfillment. The health bill you refer to which you believe will help to alleviate the physician shortage in rural areas may, or may not, yield the results you desire.

A key factor in the production of primary care physicians is not the medical schools, but Family Practice residencies in community hospitals operating in affiliation with medical schools. It is in these residencies that primary care physicians receive the best preparation for practice in rural areas and it is these programs which need support. At this point in time, Iowa has six established Family Practice residencies, including the one in the University of Iowa. Most of those graduating from these programs are settling in small towns. Here in Broadlawns, alone, we now have twenty-nine Family Practice residents, eleven of whom will enter practice by July, 1977. Meanwhile, we are recruiting for next year and are being deluged with applications and inquiries from all over the country. We anticipate that we shall end up with over one hundred acceptable applicants for ten available slots in our first-year program. These young people all want primary care training and eventual settlement in rural areas.

My point is that most of these applicants do not want a residency in a university setting and they do not have to be sold on settling in small towns. The community hospitals, which can give them the training they want, do need financial help beyond what is currently available. This is because most community hospitals were not built to be educational centers and are not budgeted to meet the cost of salaries, faculties, housing, equipment, and such things as additional classrooms, conference rooms, and examining rooms. The cost for education cannot be passed on to patients and must come from other sources. Some State and Federal funds are being allocated for these purposes, but they do not come close to meeting the total cost and many programs may fold for lack of proper financing.

In some quarters it is erroneously believed that medical schools turn out Family Practitioners. Medical schools merely prepare students to enter residencies, which produce specialists, including Family Practice physicians. Most specialties need the facilities of a medical school for proper training, but the Family Practice specialty thrives best in a community hospital, *if* that hospital is enabled to bear the cost.

All of this may be well known to you, but I felt I must speak for the community hospital element in health care education. I hope you find this to be worthy of your support and that the means can be found to help us to do our job properly. With help, the programs in Iowa and elsewhere will annually turn out a steady stream of highly qualified Family Practitioners for the communities where they are so badly needed.

With best personal regards,

SIDNEY L. SANDS, M.D.,
Director of Medical Education.

DEPARTMENT OF NURSING,
GRAND VIEW COLLEGE,
Des Moines, Iowa.

DEAR SENATOR CLARK: The role of the professional nurse in the delivery of health care to individuals living in rural sections of our country should be carefully reassessed. The panel presentations focused on the restorative aspect of delivery of these services and only briefly mentioned the promotion of health and preventative health care.

In our brief conversation, I mentioned our new baccalaureate program at Grand View College in Des Moines with its unique approach of developing neighborhood nurse clinics in the churches in close proximity to the College. It is our objective to prepare a nurse capable of giving nursing care in numerous types of settings and dedicated to the promotion of health. Individuals visiting these clinics will be assessed as to their health status and referred to a physician if deviations from normal indicate the need. Various disciplines such as a dietician, dental hygienist, and social worker are available.

During your hearings, I sincerely hope you identify the need for making both health care and restorative care available with third party payment for both

aspects of care. Schools of nursing committed to this concept need your financial assistance and backing. Current methods of health care delivery are not adequate, and new methods need to be devised since health promotion is, in essence, less expensive.

I would appreciate any knowledge you can forward to me about possible grants that would provide necessary monies for equipment and necessities for these nursing clinics.

Respectfully yours,

TERESA NEOFOTIST,
Administrative Assistant.

IOWA DEPARTMENT OF SOCIAL SERVICES,
Clinton, Iowa, October 11, 1976.

DEAR SENATOR CLARK: I am writing in regard to the recent letter I received from you on the rural health care hearings you'll be conducting in Iowa later this month. I hope to attend Tuesday, October 19th at Eldridge Turner Hall, Eldridge, Iowa.

Homemaker Home Health Aides deal daily with the elderly and know their multi-problems. We are caring for many elderly where we do all of their business, make doctors appointments, get groceries, light housekeeping, tell them about the different benefits that are available (besides do all the paper work), get their food stamps, etc. Many who have studied the needs of the elderly believe they should remain as long as possible in their own home. Even when chronically ill, they may do well at home with help.

Homemaker Home Health Aide Services are one of a number of services that are available to individuals and families provide by the Department of Social Services. The services complement the broad range of Social Services by providing agency trained and supervised homemakers in the homes of families and adults to assist with the maintenance and managements of their homes; upgrade family levels of living; assist families and individuals, provide care for the children or personal care for ill or disabled family members; to care for the elderly by helping them remain in their homes and be able to function at their ability with the care and assurance of a trained homemaker.

Homemakers work under the supervision of a Caseworker, Visiting Nurse or another member of the professional team responsible for helping to resolve the problem that the service is necessary in a particular home. The goal is to better the quality of daily living through demonstration, encouragement and support in whatever areas the family or individual needs.

We have 90 cases in Clinton County (118 adults and 54 children) that 7 homemakers service, 65 of these cases are on S.S.I. Jackson County has 33 cases (40 adults and 20 children) that 3 Homemakers service, 28 of these are on S.S.I. Scheduled times are set according to the specific needs of a client, this could mean daily, bi-weekly, or weekly visits. Six clients are blind, one client lives alone though he has both legs removed, 8 are stroke patients, 6 are in the nineties, several cancer patients, a large number in wheelchairs, etc. All of them remain in their homes due to the assistance of a Homemaker.

Whenever a Homemaker Home Health Aide Program exists, its' worth has been proved again and again. We are directly involved in promoting the well-being of others. Every individual needs a feeling of self respect and dignity in order to be happy. In the long run, the program saves money by eliminating some very expensive alternatives such as foster care and nursing care but most important, it is a way to make the world a better place for many people simply because someone cares.

Sincerely,

JUNE J. JOHANNSSEN,
Homemaker Supervisor.

MEYLOP CHIROPRACTIC CLINIC,
Le Mars, Iowa, October 18, 1976.

DEAR SENATOR CLARK: We are in receipt of your letter October 7, 1976. The letter arrived too late and we were unable to attend your meeting in Merville.

Would you please forward at your earliest convenience information concerning your programs of attracting health manpower services and financing of rural health services. We are particularly interested in Northwest Iowa.

I hope your remaining field hearings go well. We will be looking forward to hearing from you.

Sincerely yours,

HARRY WM. HARGETT, D.C.

TOLEDO, IOWA.

DEAR SENATOR CLARK: To provide more comprehensive health care in the most economical way to rural residents of Iowa, I respectfully suggest:

Plan and carry out a training program for Registered Nurses to upgrade their skills and prepare them as Nurse Practitioners. Training programs should be set up initially for Public Health Nurses either currently employed or willing to be employed in this field. This would be advantageous due to their experience and present establishment in the health care system as liaison between the physician and patient. The RN or PHN is also the one who would actually deliver the service. Nurses with degrees would, with added preparation, end up as a supervisor or teacher. The training plan could call for one day a week of formal instruction and four days a week of "on the job training". Local physicians could be involved as preceptors to complement the experience phase. The University of Minnesota has had a similar program with faculty going out into various areas for instruction and supervision of the work phase. This type of program could be instituted through the State Dept. of Health and thus avoid high administrative costs. Perhaps dollars could be added to 314-D funds and earmarked for Family Nurse Practitioner training and/or employment.

Nurses have many independent functions so can serve the people in many ways. Their only dependent function is the administration of medications and treatments ordered by the physician. Physician Assistants are, by training, completely reliant on a physician. They can act only upon authority invested by a physician or clinic group. They could not operate a clinic or make home visits without immediate physician back-up. A nurse can give nursing care and therefore can work with all patients and also serve as a liaison between that patient and any physician he chooses. It is imperative that we retain the patient's right to choose his own physician.

Currently we are working under a grant from the Iowa Legislature to establish Well Adult Clinics at various sites to see if we can provide better medical care. We operate on a four county basis with each county also acting independently under our Board of Health. This program has been very well accepted by both patients and physicians. We visit all the small communities once a year for Clinics and later make home visits whenever we find a need. Our counties do not have the means to finance this type of program but would cooperate if the State or Federal government would help. There would be less chance of duplication if these programs are built into current agencies as an expansion of service rather than establishing new agencies such as we now have under our Rural Initiative Grant in Tama County. With a new agency, too much money goes into administration and too little into service. Our elderly, who live on a fixed income, have enough difficulty paying the high cost of medical care. This type of nursing care would fulfill a need and be less expensive to deliver. Government programs must recognize that a skilled nursing service is much more than giving an enema or inserting a catheter. Preventive medicine must be recognized as a saving of the medical dollar. Some way must be planned so subsidize this type training and service with controls under local (state or county) government, if we are to be successful.

I am a Public Health Nurse working daily with our people—rich or poor—old or young—all with a common problem—too few physicians to reach all the residents. Many do not need the definitive care of a physician, yet, but will in the future if they are not counseled and supervised in preventive medicine. Nurses in this expanded role are capable of assessment and evaluation to determine the need for physician care and are capable of helping the patient secure this care. We are now trying to fulfill these needs but are constantly frustrated as we need more staff and more training. I feel we can help to answer the problem but we need your financial help. Let us who are in the field, who recognize the needs, and who are aware of the protocol of delivery that will be acceptable to the patients and the medical professions, have a strong voice in the planning and implementation of the programs chosen.

Thank you for listening.

RUTH KEITH, R.N.

INDEPENDENCE, IOWA, *October 29, 1976.*

DEAR SENATOR CLARK: You approached rural health care in the very limited sense of doctors, hospitals and medical care. Is not "Health" care concerned with more than just these?

It is a fact that nursing is the largest "health" profession in the United States. In the rural areas of Iowa, who cares for the people who are dismissed from the hospital while still quite ill (and there are many of these due to the Medicare regulations)? What about the person who finds it difficult if not impossible to get to a doctor's office, due to the limits set by his physical condition?

In rural areas of Iowa, it is the county public health nurse who is actually giving these "health" care services.

The patient's doctor leaves the orders for medications and treatments and probably sees the patient briefly at intervals, but it is the visiting nurse who provides the ongoing care of the patient in the home, monitors the medications, observes and assesses the patient's condition, does the patient teaching, and keeps the physician informed.

I cannot argue with the need for more physicians in rural Iowa. That is a real need! However, we have official public health nursing services already doing great amounts of health care in rural areas, and these services need money and manpower to continue and to increase services, and this needs to be considered and dealt with just as the shortage of doctors does.

I invite you to spend some time with a county public health nurse to learn another aspect of rural health services.

Sincerely,

(Mrs.) NANCY A. CRAWFORD.

MANCHESTER, IOWA, October 1976.

DEAR SENATOR CLARK: In rural Iowa counties, it is almost always the case that the County Public Health Nursing Service is the only service providing nursing care (Ex.- Actual physical care of the individual in his/her home); health promotion and disease prevention (Ex.- Health education programs, health screenings like B.P. screenings at senior citizens centers); communicable disease nursing and follow-up; and maternal and child health services (Ex.- Immunizations, well child conferences, prenatal classes, health supervision of pregnant women and of infants and children, EPSDT and WIC screenings).

These County Public Health Nursing Agencies are official agencies under the County Boards of Health. This is the mechanism that can provide the delivery of the above-stated health services to the people in each county, but these agencies are understaffed because the county governments say they do not have the *money to finance* the employment of more staff or to increase and improve services.

In addition to finances for employment, there is the need for finances for education; for the staff, once employed, needs to be provided with the necessary continuing education to keep their skills and knowledge current to enable them to provide highly skilled quality services.

Many of these nursing agencies provide a further community service in that they are involved in student education in community health nursing (Ex.- R.N. students in a B.S.N. program doing some home visiting in the community and the well elderly clinic in a county where undergraduate B.S.N. students are learning assessment skills, health counselling of clients and referring and follow-up of problems discovered).

The county nursing agencies provide the cases and clinic sites and work with the student in such things as coordinating care, referring and counselling should problems arise. The school instructor provides the direct supervision of the student.

As further proof of the value of county public health nursing, I submit the six cost comparisons attached to this statement.

(1) I would recommend increased funding to county governments for public health nursing services probably via the 314d program.

(2) Before creating new health agencies to provide certain health services, I would recommend that a check be made to ascertain whether or not this service might be more appropriately provided by the already established county public health nursing services and if so, provide the funding to the county governments to enable the nursing service to expand and provide the proposed service.

NANCY A. CRAWFORD.

Enclosures.

1. Case: 75 year old male.
2. Classification of Disease: Pulmonary.
3. Living Conditions: Two story frame house in good condition. Lives with wife and son.

4. Referred by: Family—year 1976.

5. Patient's condition upon admission:

Had a very slow recovery from right thoracotomy surgery. Became very confused, combative and opened up surgical incision in upper back area. Staph infection developed and approximately 6" open unhealed area present. Copious amount of drainage was present and healing slow. During this time patient had to be restrained in bed to prevent further injury. He was discharged from Extended Care six weeks after surgery and still needed dressings changed at least two times a day due to copious drainage. He was very weak and had some lung congestion. Still confused and disoriented.

6. R.N. visited first time on Sunday a.m. after discharge on Saturday. Then visits were made daily Monday through Friday and two daughters were taught to change dressing at night and weekends. Wife was very nervous and hostile to other family members due to her fear of staph germ.

The drainage remained profuse for two months and then nurse made the visits two times a week to change dressing and observe wound for infection.

Two and one-half months after his return home, the wound was closed and the case was terminated.

7. Patient's condition at present—4 months later.

Wound is completely healed and patient is able to get around house and yard. His mind became much clearer right after return to his home and he is well oriented and alert now. No chest problem present and he has an excellent appetite. Wife had not wanted him in home and had felt he'd be too much care but he is now close to being self sufficient.

8. 64 visits by R.N. since 4/4/76 to 7/13/76, cost, \$640.00. Dressing supplies, \$58.00.

9. Home Health Care Total, \$698.00.

10. Approximate nursing home cost from April 4, 1976 to July 13, 1976, \$2,828.00.

This patient was a client for three and one-half months.

1. Case: 78 year old female.

2. Classification: Multiple Sclerosis.

3. Living conditions: small 5-room frame home in good condition.

4. Referred by: hospital nurses.

5. Patient's condition upon admission: For approximately five years nurses from the hospital had been going into the home to change her catheter so she could remain in her own home. When the County hired a Public Health Nurse in June of 1973 she immediately began serving this family. The Dr. recommended close supervision of medications as there had been drug abuse by the patient. Skin care and bowel habits also needed supervision. She ate her meals at the table using a wheelchair to get around. She was a very demanding person so the husband needed support and direction.

6. Nursing skills used:

(a) assessment and evaluation.

(b) catheter changed every 3 weeks.

(c) treatment of decubitus.

(d) evaluating vital signs.

(e) proper positioning and body alignment.

(f) note adverse and therapeutic effect of meds.

7. Patient's present condition: Patient now 81 years old. Unable to turn over in bed or move her legs. She must be placed in wheelchair. She can still feed herself. Her disposition has not improved and demands much from her husband. A Home Health Aide goes in once a week to bathe her and lend any assistance they will accept. The Public Health Nurse continues to change the catheter every three weeks. Continued supervision of skin care and efforts to promote better mental health are undertaken. Her vitals are monitored occasionally and it has also become necessary to evaluate the husband's physical endurance level and monitor his B/P and pulse. The patient's needs are reviewed every two months and reports sent to their local physician.

8. Public Health Nurse home visits from June 20, 1973 to June 20, 1976:

Cost	-----	\$420.00
Supplies	-----	147.92
Home Health Aide visits (2 mo.)	-----	18.20

Total	-----	586.12
Nursing Home care for same period	-----	18,615.00

Following are four examples of cases of patients who were able to be in their own home rather than a hospital or nursing home because the services of a Public Health Nurse helped make it possible. These four cases amounted to a combined financial savings to these families of \$12,729.45 as compared to nursing home or hospital cost.

I.

1. Case: 66 year old female.
2. Classification: Cancer.
3. Living condition: Two story 6 room frame home in good condition.
4. Referred by: Physician April 18, 1975.
5. Patient's condition upon admission: Has been critically ill at St. Luke's Hospital where she has been a patient for 36 days. She is still extremely weak being unable to walk or stand except for short intervals. She must have daily colostomy irrigations. Her alternative was to go to nursing home or have Public Health Nurse visits which she gladly accepted.
6. Public Health Nurse visited 6 days a week for 2 months until patient was strong enough to take over her own colostomy irrigation. By now she could help in the kitchen, sitting on a high stool. Her laboratory reports from the Dr. also indicated improvement. This period of recovery required 33 visits. She was able to care for herself until February when she sustained a pathological fracture of the 'R' humerous. Again nursing home care would have been required as her condition was worsening and she could not use her 'R' arm. Six-day-a-week visits were again instituted and by now her husband had also been diagnosed as having lung cancer, needing professional nursing skills of evaluation and teaching concerning better positions for easier breathing. (Note in chart from physician commending Public Health Nursing).
7. Patient's present condition: This patient was able to be in her own home until the last two weeks of her life, which ended June 15th. Her husband preceded her in death by two months. Time and again they expressed their gratitude for the privilege of being in their own home and having more time together. They had no children.
8. Total number of home visits for both episodes of illness—75. Cost, \$375.00. Nursing Home cost for both episodes—131 days at \$17.00 per day, \$2,227.00.

II.

1. Case: 74 year old female.
2. Classification of disease: Cancer.
3. Living conditions: above average two-level home.
4. Referred by: son and Doctor.
5. Patient's condition upon admission: This patient had been hospitalized for 2 months following surgery and cobalt treatment. Because of very weakened condition and the strength it would take to care for her, it was strongly urged that she enter a nursing home. She wanted desperately to come home so the family contacted our agency. The Doctor then sent a referral with instructions for professional nursing care which included:
 - (a) care of skin around stoma which was red and raw
 - (b) teach husband how to care for colostomy and change colostomy bags
 - (c) change foley catheter every 4 weeks plus observe output, etc.
 - (d) supervise diet and teach concerning medication
6. Public Health Nurse visited daily the first 4 days to give skin care around stoma, bathe the patient, and support the family. Repeated instructions and support was needed. Then starting in November, bi-weekly visits were adequate to maintain care needed.
7. 47 home visits were made by Public Health Nurse, cost \$235.00, supplies, \$25.67.
8. Total Home Health care, \$260.67.
9. Nursing Home cost Nov. 28—April 11, 136 days at \$17.00 per day, \$2,312.00.

III.

1. Case: 58 year old female.
2. Classification of disease: Cancer.
3. Living conditions: Lovely home.
4. Referred by: Doctor.
5. Patient's condition upon admission: The Doctor's office nurse called stating this patient had come home from the hospital with terminal cancer. Because of her strong desire to be home the Doctor thought it could be handled if the Public Health Nurse would assist the family with her care.

6. Patient care given: Assistance was given in irrigating and dressing the wound. The husband was instructed where and how to give injections for relief of the pain. Nurse also bathed patient once or twice a week depending on the need. As patient became weaker an indwelling catheter was inserted to relieve the family in lifting. Support of the family with their anxieties and questions was also given.

7. 12 home visits were made by the Public Health Nurse, cost, \$60.00. Family paid, \$10.00, plus supplies, \$6.06, total, \$16.06.

8. Approximate hospital cost for 27 days at \$93 per day (which is average cost per day for 100 beds or less), \$2,511.00.

IV.

1. Case: 71 year old female.

2. Classification of disease: Advanced Rheumatoid Arthritis.

3. Living conditions: old two-story home with poor plumbing and falling plaster.

4. Referred by: Doctor from Mercy Hospital, Iowa City, July 1975.

5. Patient's condition upon admission: This patient had been hospitalized for two months for treatment of large decubitus ulcerations requiring debridement, skin graft and suturing. As healing progressed the Dr. pressed them to send her to a nursing home feeling she would deteriorate into same condition that caused her hospitalization if she could not obtain special nursing care. The family wanted her home so patient was referred to our agency.

6. Public Health Nurse visited and set up plan of care for bathing three times a week, cleansing and dressing wounds, and teaching family care of an indwelling catheter, including daily irrigation of catheter. The family had not had the prescriptions filled as the patient did not want to take medicine. The Doctor's exam in the hospital discovered the patient to be in chronic congestive heart failure, so a teaching program was inaugurated and still must be reinforced. Her blood pressure and apical pulse is monitored, and catheter changed every four weeks. In a few weeks the areas on her back and legs were completely healed so visits were cut to one time weekly. We have guided the family thru drug reactions, proper skin care, positioning, and lifting into a chair.

7. Patient's present condition: There has been no more skin breakdown. Medication supervision is still necessary as she becomes very hypertensive if medicine not taken, which she tries to get by without taking. Visits are made twice a month to monitor blood pressure, examine skin and change catheter. The family often express gratitude that she did not have to go to nursing home.

8. Total number of home visits—40.

9. Cost of Public Health Nurse visits, \$200.00. Cost of supplies, \$132.80. Total, \$332.80.

10. Nursing home cost for 392 days at \$17.00 per day, \$6,664.00.

JACKSON COUNTY HOSPITAL,
Maquoketa, Iowa.

DEAR SENATOR CLARK: I wish to make a few comments regarding your hearing on rural health care held in Eldridge, Iowa, October 19, 1976.

It became obvious by the conclusion of the meeting that your concern for the day was primarily limited to problems directly associated with physicians and physician-assistant type people. Being a physical therapist, I was disappointed that more time and discussion was not directed toward ancillary personnel and their involvement with health care for rural Americans. Your comment that additional hearings might be held to address issues pertinent to people other than physicians who provide health care to rural Americans was highly encouraging, and I hope some action can be taken toward this.

Specifically, I could comment on one problem, that being the restrictions imposed on physical therapists and others by the salary equivalency provision of the Medicare Program as it pertains to reimbursement for services provided. This indirectly limits services to rural people because payment is insufficient to meet the costs of time and travel.

For example, providing consultation or treatment to a patient 25 miles from the base of operation is reimbursable at \$9.30 for time and \$4.65 for travel in the State of Iowa. Total time of travel and treatment in this situation could approximate two hours. Payment of \$9.30 for two hours time expenditure is really unrealistic for a professional person in this day and age. Traveling 50 miles at 15¢/mile amounts to \$7.50, far exceeding the Medicare allowance of \$4.65. This is but one of the problems that could be brought to the attention of people such as yourself and the Congress through hearings geared to ancillary personnel.

However, I wish to compliment you on your concern for rural Americans and their health care along with some of the problems facing the consumer, the provider, and the legislator. Good luck in your pursuit of answers for the problems we are all facing!

Best regards,

TRUMAN WILKIN, L.P.T.

FLOYD VALLEY MEDICAL MANPOWER,
Le Mars, Iowa, September 28, 1976.

Mr. DAVID HART,
Senator Clark's Office, Russell Senate Office Building,
Washington, D.C.

DEAR SIR: As a member of the Floyd Valley Medical Manpower Committee, I am writing to you in connection with our telephone conversation today pertaining to the Senator's up-coming field hearing about doctors in rural areas.

The Communities of Le Mars, Remsen and Marcus have been actively recruiting medical doctors since the first of the year.

Le Mars is presently staffed by two clinics and each clinic did have three physicians. However, three physicians, two in one clinic and one in the other clinic have retired. We are now seeking four physicians, in replacement. Remsen has one physician who has expressed the desire to retire in the near future. They are attempting to attract two physicians. The Marcus Community has a modern medical office building but no full-time physicians. The office is staffed two half days a week by one of the Le Mars Clinics.

The present medical staff of Floyd Valley Hospital, located in Le Mars, consists of four family practitioners, one board-certified general surgeon, one board-certified radiologist, and a podiatrist.

There is ample evidence the people of Le Mars want good medical service. The city of Le Mars purchased the current Floyd Valley Hospital from a private organization in 1966. The purchase was made possible through a \$300,000 bond issue approved by over 90 percent of the voters. Because of the fact the building was over 50 years old, plans were made for a new hospital in 1972. One-point-five-million-dollars was raised through donations and pledges. Rising costs brought about the necessity of a \$500,000 bond issue which was again overwhelmingly approved by the voters. An additional \$200,000 came from Federal funds and that amount was used for the purchase of new equipment. The 2.2 million dollar facility, with 44 beds, opened its doors on June 12, 1976.

Of course, this facility is threatened by the shrinking number of doctors. The Floyd Valley Medical Manpower Committee, comprised of interested citizens and business people, was formed in January of this year. The first goal of the committee was to raise a minimum of \$20,000. The committee determined that the money would be used to conduct a national advertising campaign, (using medical journals and major newspapers in the Metro areas), paying the costs of hosting prospective doctors and formulating an on-going program that would provide an adequate number of doctors in future years.

The method used to raise the needed funds was a radio marathon program. The program was a day-long event through the facilities of Radio Station KLEM in Le Mars. The marathon was held January 24th. That part of the search for medical manpower was a success beyond expectations. The marathon brought in a total of \$64,692.00.

Thus far, we have hosted about a half dozen prospective doctors . . . have made mail or telephone contact with approximately 40 to 50 others, and up to this point we have been unsuccessful in getting a doctor to locate in our community.

Our prime concern, of course, is an adequate number of physicians. We are dangerously low according to the recommended ratio of doctors per population. In addition, the lack of doctors practicing in the community is definitely having an economic impact in that local citizens are being forced to go elsewhere at times for medical service. While in other communities for that service, they naturally spend money for other needs.

I apologize for the length of the letter but hope it explains our plight. Let me know if I, or other members of the committee can be of further assistance.

Sincerely yours,

LARRY V. SCHMITZ,
News Director,
KLEM Radio.

STEPHENVILLE HOSPITAL & CLINIC,
Stephenville, Tex., October 22, 1976.

DEAR SENATOR CLARK: I read with interest an item about the hearings you have held on the rural doctor shortage.

We have an 88 bed hospital with eight doctors and we have a service area of over twenty thousand. We have trouble getting more doctors and the main obstacle is that HEW won't allow us to charge on the same basis they will a doctor with the same training in Fort Worth. We have a population of about 11,000 counting the students in the college here. We had one doctor who went for urology training and did not rejoin us because all he could get for a TUR here was \$300 and could get \$500-\$600 in West Texas in a town of about 35,000. One of my associates is a board certified ophthalmologist who has the AOA and eye training who did come back for financial interests and to become associated with his father who is our EENT man. The ophthalmologist gets \$300 for a cataract and in the nearby towns, the doctors who have less training and experience than he are getting \$1000. The thing I'm pointing out is that HEW ought to allow us a little more on the good quality medicine we do with the same amount of training of the "city" doctors and this will help us obtain more doctor help. We advertize \$40,000 per year guaranteed but still have not gained more help.

Would you help us in the rural areas get better prices for the work we do and that will go a very long way in getting doctors to consider moving to the smaller towns.

Respectfully,

J. C. TERRELL, Sr., M.D.

PUBLIC HEALTH NURSING ASSOCIATION OF LINN COUNTY,
Cedar Rapids, Iowa, October 26, 1976.

DEAR SENATOR CLARK: Thank you for your correspondence dated October 1, 1976, and a copy of your speech on the federal role in rural health care.

As the Director of a voluntary, non-profit, incorporated community health nursing organization, I was pleased to read that Congress too is interested in utilizing nurses in expanded roles to help meet the health needs of rural communities. It has long been my feeling that nurses with guidance and proper medical support are capable of managing clinics for health counselling and supervision as well as health maintenance. Part of the spiraling cost of outpatient medical services is the patient who visits a doctor every two weeks or once a month to have his blood pressure checked and must pay the full office visit charge each time. The same type of thing is evident for pregnant women who are seen initially by the physician and then checked monthly by the office nurse, yet pay an exorbitant charge for an obstetrician.

Public Health Nursing Association of Linn County is the second largest community health nursing service in Iowa. The largest being Des Moines, Polk County. At PHNA, we are funded by the Linn County Health Center and United Way as well as fees for service. We are continually looking for ways to not only get health services to all parts of Linn County, but also to assure the quality of these services.

We are now in our second year of funding on a Grant from the Iowa State Department of Health Division of Maternal and Child Health for the Expansion of Comprehensive Health Supervision Services Into Rural Linn County. Transportation continues to be one of the main obstacles. Even though Well Child Health Conferences are located all over the county, people have difficulty getting to them. Also, many people do not see themselves as poor or in need so do not feel they qualify for many available services.

More recently, I wrote a grant request to HEW (Public Health Service Catalog No. 13.224) to expand geriatric services in Linn County. The money requested is to pay the salary of a Geriatric Nurse Practitioner. We had a minimum of fifty Well Elderly Clinics last fiscal year (July 1975-June 1976) serving about 225 people. Requests for more clinics come in every month. I feel very strongly that gerontology has become a specialty area and that my staff nurses need access to someone with expertise in adult health.

I encourage your efforts to improve the quality of life by increasing the availability of comprehensive health care.

Sincerely,

JUDIE MUENCHOW,
Executive Director.

MOLINE, ILL., October 21, 1976.

DEAR SENATOR CLARK: Although not from your state of Iowa, I do live in an area where the events of your state are reported on a par with those of Illinois, and yesterday a synopsis of your evaluation of the medical care availability problem in Iowa was broadcast. I would like to commend you on your perceptiveness in recognizing the basic problems and sensible solution to this problem of providing quality medical care to the rural areas. I wish that more of my colleagues would see the problem as clearly and would put their efforts into establishing such programs instead of scorning all programs except those that are only minor variations of the traditional medical delivery system.

Your conclusion that relatively easy access to quality care, at accountable costs, can best be achieved in rural areas (and with variations in undesirable, crowded urban ghetto areas) by the use of physician extenders in small satellite offices backed up by well-staffed, competent medical centers is excellent.

A reasonable conclusion to achieving this, however, is at odds with part of the Federal government's program of encouraging the training of more family practitioners. The physician extenders' abilities will be governed to a great extent by the competency, experience and erudition of the physicians supporting them—which means they should probably be well-trained and board certified. Thus, in such a situation, the family practitioner is in limbo, overly trained for one end of the spectrum and undertrained for the other.

Thank you for listening to an "out-of-stater". I wish you luck in presenting your views and logical conclusion to your senate colleagues.

Yours truly,

J. P. JOHNSTON, M.D.

DEPARTMENT OF SOCIAL SERVICES,
STATE OF IOWA,
Ottumwa, Iowa, October 11, 1976.

DEAR MR. CLARK: Thank you for your letter inviting me to the Health-Care Hearings, and informing me of your part in the Congressional Debates.

As a Homemaker Health Aide Supervisor in a predominantly rural area, I must express my concern for adequate Health-related resources. Although the Jefferson, Van Buren, and Davis County area is considerably better staffed than some, at least one clinic is turning away new patients to insure time to serve those already on the records. This area saw two Doctors retire in 1975 and will see another retiring soon.

As a public servant to many low income elderly I support the programs which will aid medical students and the Nurse Practitioner Program, but I am most interested in the new legislation which will expand the use of the nurse practitioners and other forms of physician extenders. I feel the use of Homemaker Home Health Aides with appropriate training as extenders of nurse practitioners and physicians is a distinct possibility and an area well worth investigating. The Homemaker Home Health Aide program in Iowa has proved very effective and has saved our state thousands of dollars, by enabling many elderly persons to escape inappropriate institutionalization. It is much less costly to send a Homemaker into a home on a minimal schedule than full time nursing home care which the client does not need or want.

We also support families (with children) as a unit and in some cases where foster care (which costs money) would have been the answer, a Homemaker Health Aide can be scheduled into the home to help alleviate many of the tensions and/or their causes. I will welcome your response to this suggestion, further use of Homemaker Health Aides.

You have stated you will work to facilitate the utilization of physician extenders through "changes in the medicare reimbursement policies."

I would like to know exactly what changes you favor and the results you expect from such changes, how such changes will affect the low income elderly and/or family, and how homemaker home health aides will be affected by such changes.

Thank you,
Sincerely,

DOROTHY FLEAGLE,
Homemaker Program Coordinator.

SIoux CITY, IOWA, *October 21, 1976.*

DEAR SENATOR CLARK: I had hoped to be able to attend your hearings on Rural Health Problems at Menville, Iowa last Sunday, but I was unable to do so.

At times I feel that some of the departments of government are not carrying out the wishes of the legislators, although they may stay within what they determine to be the interpretation of the law.

Some months ago a physician-representative of the Health Service Corp was in Sioux City. Sioux City, as you may know, covers a large area for our population. The Morningside area of Sioux City has about 30,000 people, but of course, it is part of the city and is not an entity itself. It has been my understanding that the Health Service Corp was established to help obtain physicians for deprived areas and certainly our rural areas would fit into this. However, apparently the Service Corp has had difficulty in attracting doctors to go to some of the rural areas so at least this physician had come here to see about establishing one of their offices in the Morningside area. When that neighborhood itself is considered, the number of physicians per population, of course, is below the number required for a deprived area, but when the city of Sioux City is considered, our average is well above that. I pointed this out to him but apparently he felt that they had a lot of latitude in determining population figures.

We are in need of physicians in Sioux City and after a lengthy and heated discussion, and very much against my opinion, the Woodbury Medical Society did vote to seek this help.

The remainder of Woodbury County has no physicians outside of Sioux City and a project such as this would have been ideal for one of our rural areas. Instead, the money is being used to establish an office and to fund three to five physicians in a city which cannot be considered deprived.

Perhaps it would be beneficial for the legislature to check on these various agencies to determine that the intent of the legislation which they have worked so hard to pass is carried out.

Thank you for your courtesy in this regard and also thank you for spending your time looking into our health needs.

Sincerely yours,

GEORGE G. SPELLMAN, M.D.

SURGICAL ASSOCIATES OF NORTH IOWA, P.C.,
Mason City, Iowa, October 20, 1976.

DEAR SENATOR CLARK: I spoke with you briefly at the close of your hearing on Rural Health Care in Traer, Iowa, to invite you to meet with us in Mason City, Iowa, to talk about rural health care. We pretend to no revealed truths but claim some insights gleaned from composite experience tested against conventional wisdom and modified by liberal borrowing of ideas from every source we have been able to find. We are left with the conclusion that the problem is extraordinarily complex, that no easy solution exists but that systematic approaches are readily applicable and that these will lead to considerable betterment albeit somewhat short of Utopian ideals.

We take as the objective ready access to an orderly process of health service, conveniently available to every individual of our area, providing a type and level of service appropriate to each individual need. We believe furthermore that health costs are out of control. Containment of those costs will require that duplications of services not occur and that each patient pathway through the system is made upon reasoned judgment to assure that each service provided is both necessary and effective. Finally, we believe that rational compromises can be made to utilize existing components and facilities, many products of past errors of health planning, by re-defining their use within a new management process; in short we believe that health care can be systematized if one is able to define the population to be served, respective roles of health workers, means to assure competence and continued competence, lines of communication and clear channels of referral. Cost containment demands that every service be provided adequately but in the least costly environment. Simply stated, every patient should be treated as an ambulatory patient unless he has clear reason to need specific professional medical services while in bed. If he does, he should be in an institution equipped and staffed to provide only that level of service which he requires. The general hospital, functioning as a hotel for sick people, has had its day.

The nine county NIAD area is now prepared to launch a program of health services based upon community and local professional resources to provide comprehensive health services and education both for the public and to assure con-

tinuing competence of the providers. Finally, we have offered to the University of Iowa the opportunity to utilize this systematic health service for primary and secondary care for the instructions of its medical students in order to overcome the real and difficult problem of appropriateness of medical education to the needs of medical practice.

If this sounds interesting to you, I know that I speak for my colleagues when I repeat my invitation to you to come see what we are doing.

Respectfully,

NORMAN W. HOOVER, M.D.

BODE, IOWA, October 15, 1976.

DEAR SENATOR CLARK: Today I received your letter in regard to your rural health care hearings in Iowa. However, due to my schedule I will be unable to attend any of them.

I practice in a little town of approximately 450 and enjoy the rural setting with the less hectic pace of life; also the hunting and fishing available aid to the romance of rural life. House calls are part of this practice and really are necessary because of the number of aged individuals. I know that when I am called to go on one, it is usually for a serious reason—nothing minor and this helps.

The only problem I have is Title 19 and that is a financial one. It seems that the Iowa Carrier has its own fee schedule for certain areas. Several doctors other than myself find this to be true.

For example if I lived in a city instead of the boon docks, I could charge almost 2 to 3 times more and get the full amount. Now living in a small rural town, I get cuts or no payment for my charges which are low to begin with.

I charge \$6.00 for a office call which is the same for everyone seen and I believe this is lower than most places, yet Title 19 will refuse to pay or will reduce the charge. Complete lab urinalysis with micro exam I charge a standard \$3.00, yet Title 19 cuts it to \$1.00. Title 19 also refuses to pay if I see the patient more than once for the same condition and Mr. Clark, this is not good medicine because revisits are necessary to see if the medication prescribed is working.

On hypertensive patients which are hard to control, Title 19 refuses to pay for any visits unless they are approximately three months apart and I feel that the patient could be dead or worse yet have a disabling stroke by the time their blood pressure is rechecked.

We have no drug stores in my town and patients must go 14 miles for medicine. I stock antibiotics, cough medicines, and asthmatic medications for my patients and charge just a little over my cost but I cannot dispense to the welfare patient because I will not receive any payment from the carrier. This means that these people on welfare must drive 14 miles to get their medications and pay for their gas and oil.

Unable to stand the expense of the accounts receivable from Title 19, I sent registered letters to each of my welfare patients stating that due to lack of payment from the carrier, I must have them find another doctor within 30 days and that I will give them their records. However I still continue to see them because no other doctor will accept them because of Title 19 payment.

I am enclosing four charge cards to show you how things are going with payments from the Title 19 Carrier.¹

It is always sad to see in the papers how some doctor has ripped off Title 19 but after living with the experience I've been having, I say more power to them; for the reason being the company who is the Carrier just won't have such a good profit margin.

Thank you for your valuable time taken in reading my letter, I regret that it was so lengthy, but I hope you can see why doctors are not keen on settling in small rural America when payments from a well intended program are so small or not at all.

Sincerely,

F. L. TEPNER D.O.

GRIMES, IOWA.

DEAR SENATOR CLARK: I could not stay for the entire meeting. I would like to know what real effort is being made to get doctors into rural areas.

I know para-medics can help but even some doctors would not use them! Doctors need education in this matter too!

I appreciate your efforts.

Rev. P. L. KUITNE.

¹ Retained in Committee files

IOWA CITY, IOWA, *October 9, 1976.*

DEAR SENATOR CLARK: I received a mailing on your bill to attract more doctors to rural areas to practice and I wish to express my feelings on the lack of doctors in these areas in response to the mailing. I am a Zoology major at University of Iowa and have applied to medical school for the 1977 fall semester. I have had a great deal of exposure to medical students and the topic of rural practice has cropped up into conversations repeatedly.

One alluring asset that metropolitan areas hold over rural areas is their offer of cultural events. The medical student has been educated in a rich, cultural atmosphere for 7-10 years. In Iowa City, I live only a 5 minute walk away from Hancher Auditorium which I frequent more and more often as my education progresses. I have the opportunity to hear great musicians and to see plays performed by professional theater groups not to mention the dance companies and new creative arts that also come to Hancher. The art museum is a 10 minute walk away. Compare this to my hometown, Guthrie Center, Iowa. The high school plays were the "boy meets girl" type and the nearest indoor movie theater was 30 miles away featuring John Wayne and X-rated movies. My life has been enriched a great deal in Iowa City and I would like to live in or very near a place like this the rest of my life.

One might argue that a doctor in a rural area such as Guthrie could drive to Des Moines for the culture that he or she seeks. Surely one must look at other aspects of future life styles and the lack of available energy that will alter these life styles. I can say I'll practice medicine in a small town traveling elsewhere for cultural enrichment, but I am too sensitive to the wasting of energy that results from continual trips to places like Des Moines to make the trip often. This would leave me in a rural area with nonavailable fine arts at a future time when humans must alter life styles due to the dwindling supply of petroleum.

Another reason why medical students are specializing and staying in metropolitan areas is that in a specialty they will see many more interesting cases and most specialties cannot be supported by rural populations. Medical students have told me that rural doctors wipe noses, check ears, give physicals, and do other routine things, having an unusual and challenging case only once in a while. In their medical education here in Iowa City, doctors tops in their specialties come to lecture them on fascinating cases that they have worked on and "resolved." This offers an enticing creativity and necessity of thought to students who want to be doctors partly because they desire to break away from routine jobs.

How can the dilemma of the dwindling rural doctor be solved? Clinics could be set up supporting several less specific specialties, but again we run into the problem of energy waste in traveling to see the doctor. A clinic would have to support a larger area and the relative waste of gasoline would be greater as patients travel to see the doctor than if a general practitioner settled in a rural area and traveled to a metropolitan area for cultural diversion.

It is hard to say whether rural areas will develop their own adult theater groups and musical groups in the future. This may or may not entice young doctors away from the city to practice rurally.

One thing that must be emphasized in small towns is the nearness to nature that cities fail to offer and the friendliness of the people. These are the things I miss living in Iowa City and sometimes I vacillate between whether I want to be close to the natural beauty and culture of the world or the man-made culture that cities have developed to a high degree.

One other thing I must mention about metropolitan vs. rural practice or specialty vs. general practitioner practice. Once a doctor is in a specialty or practices with a large group of doctors, part of the overtime "on call" time is eliminated. He or she can possibly have more freedom to plan outside time with no worry that a patient will be neglected. Americans have been pampered with weekends and large blocks of free time. My hometown doctors don't have such freedom at times, for if one goes on vacation, the other one is overworked.

These are just a few points that I can think of to explain the dilemma of rural areas. I hope you can find a solution to the problem. If you have any questions about what I have stated, feel free to ask. I'm open to helping you in any area that I can.

Sincerely,

ELISABETH M. LOEB.

DEAR SENATOR CLARK: We feel that any medical student who gets a tax supported scholarship should give some time to areas that need medical aid.

Many of our friends' children have had "free rides" while father is busily paying for two thousand acres of land. The child is always eligible for scholarship if father pays no income tax, and yet is able to give the child a sports car when needed.

These people should be required to put in time in needy areas. Time should be commensurate to amount of aid received.

L. W. and VIRGIE LARSON.

IOWA CITY, IOWA.

DEAR SENATOR CLARK: I just want to let you know that your idea on solving the rural M.D., Nurse, P.A. Team concept in satellite clinics is great. It seems finally somebody has become realistic enough to see that just increasing the amount of graduating M.D.'s doesn't mean they end up where there is the greatest need for them.

I have to admit I probably am biased on the subject due to the fact I am a 2nd year P.A. student. In the long run however I do believe that this type of health care delivery will have a distinct advantage.

One of the advantages being that malpractice suits should decrease due to increased time being spent on difficult cases by the M.D. thus establishing better patient rapport.

If you have any plans on introducing this type of health care system in Iowa on a large scale, I would be very interested in hearing about them.

Sincerely yours,

JON VANDER MATEN.

OCTOBER 21, 1976.

DEAR SENATOR CLARK: I was a bit distressed after attending your public hearing in Mechanicsville, Iowa, last Monday. It seemed that the public did all the hearing and you and the "experts" did all the talking. There are probably two good reasons for this:

(1) It is essential that you collect pertinent information from the experts in the field of health care delivery. Because this in itself is a time-consuming process, this leaves little time for gathering other input.

(2) People are reluctant to come forward to speak even when given the opportunity or invited to.

Still, I believe a certain group of experts are being neglected—the consumers. That is why a group of medical students at the University of Iowa is forming a Committee on Rural Health Care. Our goals are two-fold:

(A) to better educate medical students on existing and projected state of rural health care organization, needs, and manpower;

(B) to better understand what consumers see as their needs and to inform them of trends and alternatives in rural health care.

In a few days, George Shoephoerster, a second-year medical student at the University of Iowa, will be writing you relative to the specific objectives of our group.

Now, let me simply reiterate my testimony at the hearing. I urge medical educators to begin providing learning experiences that will better prepare the primary care physician to:

(1) practice less sophisticated medicine;

(2) work in health care teams (Public Health Nurses, P.A.'s, Nurse Practitioners, Clinical Pharmacists, Family Councilors, Dieticians, Social Workers, Therapists);

(3) practice home health care;

(4) provide health education and preventive medicine.

If this education is offered, and the proper role models are given exposure, then we might see two or three physicians feeling comfortable in a town of 1,500-3,000. Teams of various health professionals would provide peer security, consultation could be done on the phone, continuing medical education could be learned at hospital staff meetings or medical society meetings, and the physicians would know how to optimally use and rely upon the available technology.

Keep in touch; we'd like to have you come to our school and talk sometime! Good luck with your report.

DAVID LOXTERKAMP.

KNOXVILLE, IOWA.

DEAR SENATOR CLARK: I was disappointed that nothing was brought out about National Health Care. For instance, if in the event of National Health Care how this program could be incorporated into it, and if some of the existing facilities

could be cut back because of rural health centers. The way it is the poor family often does receive better health care than the medium income family, with the medium income family paying the bill.

As a nurse, I have found that one family could be cared for by as many as 90 agencies. (This was a case history discussed at a seminar on social services at Iowa State University.)

The idea of Rural Health Care is great and definitely a needed program. If, however, some of these agencies could be disbanded because of it, it would be even more of a step forward. For instance, mental health clinics, dental clinics, prosthesis clinics, public health clinics, immunization, social welfare, family health care, family planning, home care, etc. etc. becomes a never ending list. Surely some of these programs could be combined and dispensed as a unit instead of the varied and diverse overlapping of the services. A program of this sort would be giving total care to those people that as the doctors stated they got to know so well. Care could improve as a result while also lowering costs. I also feel that with a National Health Plan this will have to be done, and so hope we will get a National Health Plan. Thank you for your interest and the chance to expound my views.

BERNADENE MCCOY.

Laurens, Iowa, October 16, 1976.

DEAR SENATOR CLARK: Thank you for your letter of October 7 inviting me to attend your hearings about rural health care. I would like very much to attend the hearings but I doubt that will be possible. You asked for suggestions so the following could be a possible program lay-out.

First, let me explain my job. I am a Site Manager of Laurens Congregate Meals. This is a Title VII program and is sponsored by the Area Agency on Aging. We are part of the Pioneer Trail Nutrition Project.

I am not fully aware of the problems of rural health. I do feel that good nutrition is the basis of good health. The essence of my suggestion is to incorporate health programs into existing nutrition programs. I'm sure the financial arrangements would be more satisfactory than the cost of developing a new program.

This section of Iowa has a large number of nutrition sites for the elderly at present and more are scheduled to open. We provide well-balanced meals, nutrition training and medical training and clinics are available to us. The medical services could be expanded through specialty screening clinics such as free blood pressure, Glaucoma, X-ray, T.B., Diabetes detection and vaccination clinics. These services are already available through county medical offices. Much of the labor is volunteered.

How does this tie in with rural health? At present the rural population is poorly represented at the nutrition site. The problem is transportation. This problem can be solved with mini-buses or volunteers whose mileage is paid. Another problem is information. A mass campaign would need to be launched to stimulate interest. The program could be expanded to include low income people with coupons much like the food stamp program.

Financing is a problem with any program. I feel it would be less costly to utilize the existing facilities, services and personnel. At present, the in-kind donations into our program are considerable. Each participant is asked to donate according to his ability. Most are willing to help pay their way rather than have a hand-out. Many appreciate having the service so much that they pay beyond their ability.

One matter that must be considered is administrative costs. It is astounding the number of people required to administer this program. It appears to me that the lion's share of money is spent on that level and very little filters down to the program objective level. Many of the personnel are handling duplicate paper work and forms. It is unfair to the tax payer and program participants to support such waste.

In summary, I feel that programs should be merged as much as possible and that these two programs could effectively be merged.

I have a few comments about the program I serve. Some serious problems exist and the program guidelines should be re-evaluated.

The guide-line for the cook is to prepare a well-balanced meal for 75¢ per plate or less. Her duties are to shop for groceries, prepare the meal, serve the meal, clean up after, plan menus and do an inventory that requires one hour per serving day. She is to accomplish this in 5 hours per serving day or less. The meal cost guide-line allows for only the least expensive foods but does not allow the extra time required to prepare them. An example is: it costs us \$2.30 labor and approximately \$1.00 food to prepare birthday cake. It cost us \$4.60 to buy that cake prepared. Ham involves very little time to prepare but costs 50¢ per serving. Swiss steak requires

1-1½ hours to prepare but costs only 35¢ per serving. To prepare 30 servings (project minimum) considering labor and food cost we save \$2.20 by preparing the less expensive meat. However, the cook will not be paid for this time if it takes her more than 5 hours. When the 5 hour guideline was established—the inventory, the—cook did not have this time consuming inventory. There is no allowance made for the extra time involved in doing extra work. I feel the cook needs 7-8 hours per serving day to accomplish what is asked of her or she needs a more generous food cost allowance. Presently the cook at our site spends 9 hours per day to fulfill the food cost, nutrition requirements and book work requirements of her job. No one wants to work hours like these and not be paid for it.

The guideline for Site Manager requires that I prepare the site for serving, help serve the meal, arrange for volunteers to deliver meals to shut-ins, clean after each meal and generally to keep the program going. I am allowed 5 hours per serving day and one hour of that is required to be spent helping the cook. It is not unusual for me to spend 8-12 hours per day doing job required tasks. At present I volunteer many, many of these hours to the program. I feel a reasonably fair arrangement would be to allow 6 hours per serving day and then have my superiors attend the meetings I have to attend or make special allowance for paying me for those hours. I must add that our site has been in operation since February and so the volunteer program is not fully developed. Many of my hours are spent coordinating volunteer services.

Each site is required to have a sponsor or sub-contractor. Our sub-contractor is resigning due to the demands upon them by the Agency on Aging. The sub-contractor's services are strictly volunteer and they do all the bookkeeping, payroll, and reports of the project costs. I am not fully aware of all the reasons our sub-contractor is resigning, but I do know that the program was misrepresented to them by the Agency on Aging.

Without a new sub-contractor the Laurens site must close on January 1, 1977. We have 150 or more persons whose lives will be affected plus the cook and myself will be unemployed. I'm sure it is too late to help us. The Agency on Aging is depending on me and the former sub-contractor to find a replacement, but they will not allow me the time to do so.

Please investigate this program. The gossip I hear from other sites is that their situation is much like ours. This is a fine, worthwhile program and it deserves a chance to work. Our seniors have earned the chance to live out their lives in dignity with the self-reliance this program gives them.

I suggest that questionnaires be sent to the sites asking detailed information about actual time spent and realistic food cost guidelines.

Thank you.

RUTH COPE.

TRAER, IOWA.

DEAR SENATOR CLARK: The problem of obtaining adequate health care for people in rural areas goes beyond the main question which was dealt with today, that of recruiting and keeping physicians. It should also be concerned with how people pay for their health care. The present system of third party payers, both Medicare/Medicaid and private insurance carriers, is fraught with red tape, waste and scandal. I believe that prepaid health care plans, popularly known as HMO's, deserve a wider trial in rural areas. Tama County, in which a representative board already exists to administer the Rural Health Initiative Grant, has an adequate sized population to support an HMO. In addition, with 3 out of 7 physicians already on salary via the National Health Service Corps, funding would be less of a problem. I believe that the idea of locally-controlled rural HMO's deserves further study.

NORMAN P. WESTHOFF, M.D.

OSCOLA, IOWA.

DEAR SENATOR CLARK: In addition to my previous statement concerning the apparent unavailability of surgeons in County Hospitals of rural Iowa, I may suggest that since one of the panel physicians stated that perhaps the cost of malpractice insurance didn't justify one day of surgery per week—perhaps a government subsidy of the increased insurance to 40-60 bed hospitals would allow them to obtain a surgeon to join existing family physician groups. The \$6-8000 per year subsidy would be a fraction of the cost to Medicare and Medicaid by ambulance trans. to large cities and 2-3 times the going room rates, operating room charges, etc. charged by large hospitals over small local institutions.

JAMES A. DUBBELS.

CHARITON, IOWA.

DEAR SENATOR CLARK: We believe health agencies can meet the needs of persons needing intermittent health care in their homes. Right now medicare or medicaid will not pay for nursing services of a preventive or observation such as B/P checks, filling syringes for blind diabetic for home bound. Of course the person must be home bound before any medicare payments are made which eliminates any fee when you see a for teaching reasons that should be done by the nurse.

We were fortunate in getting funds for a parttime nurse for 3 years. Hope this grant will be expanded. We are told 314D funds are being cut (this would be hard on counties to assume all expenses unless good fees were coming in for services.)

MIRIAM HIBBS.

BELLEVUE, NEBR.

DEAR SENATOR CLARK: Congress must act soon to correct the inequity that exists in relation to medical reimbursement policies for physician extenders of the entire concept will be in jeopardy. It makes absolutely no sense for one government agency to be making grants for support of physician extender programs and another refusing to reimburse for the medical care rendered by these professionals. The physicians I know are very upset about the demands placed on them by the Medicare regulations and now that it appears they can obtain some help in the form of a physician extender they are told that the Medicare law does not permit reimbursement for the services rendered by the physician extenders.

Let's get our head out of the sand on this issue and recognize that some persons other than physicians can, and are willing to provide quality medical services under the supervision of a physician. The persons that are the real losers are those elderly ones in the extended care facilities.

That physician extenders will live in remote areas has been well proven in Nebraska and in other states. Let's take whatever legislative action is necessary to facilitate the physician extenders concept and let's do it now!

JESSE C. EDWARDS.

CRESTON, IOWA, *October 30, 1976.*

DEAR SENATOR CLARK: Thank you for your invitation to attend one of your rural health care hearings in Iowa in October. I was out of the state visiting my son and family. But because of an involvement in the newly enacted P.L. 93-641 (covering Health Systems Agencies) I am very much interested in your discussions on health and concerns with rural health.

The HSA program—which is organized as you know into a single statewide unit, practically, in Iowa—has this very rural health delivery problem as one of its priorities. Input from local citizens is most helpful in these efforts. Leading concerns in rural areas include cost of health services; availability of doctors; maldistribution of health facilities, or lack of facilities. It is easy to say—get us a doctor. But small rural towns are difficult to provide with doctors. Doctors aren't locating individually anymore (they can't because of night and day demands), and small towns sometimes don't provide enough overall business for two doctors. Not in comparison with what they can achieve in larger communities. So it is important that such communities band together in seeking such services.

As a member of the Iowa HSA board, I appreciate information about rural concerns (as well as Iowa concerns generally) which your hearings develop. We can't assign doctors to this spot or that. But we hope there can be developed a climate and a system that will encourage a better distribution of health service—and of course seek to keep costs in line.

Read with interest your comments in the senate about federal role in rural health. You touched on concerns our HSA is already at work on. Your suggestion of nurse practitioners and physician extenders is a possibility. There is need to establish some kind of malpractice protection, by insurance or what have you, in this area. Doctors are showing increasing interest in working on these problems, as well as consumers, with health delivery people. These are positive items.

Cordially,

E. J. VAN NOSTRAND.

TOLEDO, IOWA.

DEAR SENATOR CLARK: You were incorrect when you said at the Traer meeting "—the problem is not doctor shortage." The problem *is* a doctor shortage. If it were corrected, there would be more doctors in rural areas, a slowing of the rate of increase in doctor fees, and less reliance on foreign trained doctors.

You were correct when you said that there was poor distribution of doctors. Economic forces should function to correct this.

One reason for the doctor shortage is the increased specialization. The University of Iowa Hospital now has new departments of Vascular Surgery, Nephrology, Rheumatology, and Adolescent Medicine. Such specialization encourages students to become specialists.

Of the 16,000 doctors that were licensed for the first time last year in the U.S., almost 50% were foreign trained. Of course, you know that in most foreign countries, a student enters medical school directly from high school. Also, it is not uncommon for foreign medical schools to have over 1,000 students in one class.

Consider these statements: 1) A relatively high percentage of medical students come from small towns. 2) Most medical students in the Middle West locate in the East or Far West. Iowa taxpayers should complain about educating doctors to practice in California. That burden should be shared by all taxpayers. The federal government should not decree where a doctor should locate. However, the federal government could help expand the Medical schools by awarding them a bonus for each student graduated in addition to their usual number of graduates. The answer is: correct the doctor shortage by increasing the number of American trained doctors.

C. W. MAPLETHORPE, M.D.

DEAR SENATOR CLARK: Thank you for inviting me to the rural health care hearings you conducted in October. I wish I had been there but could not make it. I am not presently employed but I did receive a certification in the division of geriatric nursing (by the American Nurses Association) in 1975. At that time only seventy four nurses in the U.S. received this certificate.

I doubt that I will be working in the next few years but problems related to health care of the aged interest me.

It would be a big surprise to me if the outcome of your hearings would show that health care of the older person in rural areas is adequate!

I am concerned about inadequate nursing care even more than medical care. Because: inability for one reason or another to receive adequate nursing care means: Inability to stay at home safely or obligation to move to a nursing home before it is really time to do so. The losses that go along with a premature admission to a nursing home are familiar to you.

It is my belief that Public Health nurses are already overworked and provide many valuable services to clients of various ages. I do believe that if these services could be expanded by the addition of several or at least one nurse practitioner, some certified nurses and ideally a team of well trained geriatric home health aides this would meet many of the needs of the elderly.

The nurse practitioner can be a very efficient right hand to the physician already absorbed by a practice becoming too large. The nurse practitioner identifies nursing and medical problems. She refers the medical problems to the physician she saves him time by attending to the nursing needs immediately and follow-up on nursing and medical care. It is my impression that so far few physicians in Marshall County are aware of the role of nurse practitioner. Her role is some what resembling of the role of the physician assistant. She has been trained to do physical examinations, she has a great deal of education in terms of psychology, psychiatry psycho social need of the aged person etc . . . She is or ought to be an asset to the physician especially in rural areas.

I realize that I mention expansion of services so I can "hear" people screaming about my "spending ideas".

Well I suggest that someone seriously looks at the expense of a premature admission of the older person in nursing homes! The trauma that goes along with this causes early physical and mental deterioration! Must I go into details to explain what the care of the older person will cost them? That is dollars wise only.

If we cannot receive funds for such a program I suggest we consider the possibility of charging a small fee for nursing care services provided. Physicians do get paid why shouldn't nursing services be paid?

In many cases I observed that many older people can afford reasonable fees but the problem is the services are not available!

I can give you names and examples! Also if the older person cannot afford the fee she would not need to be charged. I am not dreaming all this my suggestions are based on experience a great deal of observation and knowledge.

This is the first year that I'll be voting in this country. Needless to say that my heart is "democratic" and you need not to guess to whom my prayers are for!

My best wishes to you Senator, I don't need to wonder about what you are doing I know that you are working for the people. If I can help be sure to call on me.

Sincerely yours,

MICHELE P. HALA R.N., *Marshalltown, Iowa.*

DEAR DICK: Sorry I couldn't make it to your public hearings. Did see you on TV 8 news last night. I'll add one more voice of assent. That money spent for out of hospital care by paramedical persons is needed and seems economical. Many of my patients have been kept out of the hospital and nursing homes, functioning on their own thanks to public health nurses.

Sincerely,

STEVE KROGH M.D.,
*Broadlawns, Polk Co. Hospital Family Practice,
Des Moines, Iowa.*

NOVEMBER 8, 1976.

DEAR SENATOR CLARK: Less emphasis should be made to place health providers in locations which are unable to support them.

More emphasis should be made to provide low interest loans (not grants) to health providers. They must have facilities capable of providing efficient and economic health services. The problem of inadequate financing for health service providers is greatest in rural America. Here, lenders are more conservative and not as likely to risk capital on specialized buildings and equipment. The percentage of capital recovery is high from loans to professionals.

A shortage of dentists is more apparent than actual.

JOHN J. HESS, D.D.S., *Tama, Iowa.*

NOVEMBER 8, 1976.

DEAR SENATOR CLARK: I can not say enough good things about the experiences I have had with "physician extenders," but I can certainly understand the physician's concern about the possibility for misuse of the program. However, what I hear the panel addressing themselves to is the role of physician and extender in diagnosis and treatment. It seems that if we are concerned about quality health care we need also to look at their role in health screening, health maintenance, and health teaching. These are services which are vitually not available in rural areas, and I do not believe that we can realistically anticipate that the number of physicians which may be added to our rural setting will change this. I feel that expansion of community health nursing services is a more realistic answer in developing a more effective rural health care system. Although this is not a solution in assisting the physician in diagnosis and prescription of medical treatment, it has much potential for assisting physicians with: 1. Health screening by establishing well elderly and well child clinics, 2. Monitoring medical regimes for health maintenance of the chronically ill. 3. Health teaching to increase patients awareness of his condition and responsibility for compliance with physician prescribed treatment.

Many physician's forget the role of the professional nurse when they leave the confines of the hospital. Skills which they expect of a nurse in the hospital setting are not utilized in the office and community setting. The physician shortage is accentuated by poor utilization of physician time.

JANE BORST,
*Dallas County Public Health Nursing Service,
Adel, Iowa.*

DEAR SENATOR CLARK: I live in a town where doctors are becoming few and far between and those that do remain are nearly up for retirement. Although our town has succeeded in building a new addition to the hospital as a clinic, they haven't

found only one doctor to man the new facility that is new. Incentive for young doctors to start a practice in a small town is nil. With new facilities of a clinic and others also, a young med may be willing to go into more sparsely populated area.

Why can't our government supply local communities with more low interest loans and programs to cut cost of architecture and planning.

If you know of plans or are in the process of, would you please send me, if possible some of the information on helping small communities with medical handicaps.

Sincerely yours,

LOUISE VANNATTA, *Perry, Iowa.*

JACKSON COUNTY PUBLIC HOSPITAL,
Maquoketa, Iowa, November 3, 1976.

DEAR SENATOR CLARK: The physicians associated with the Medical Associates of Maquoketa, P.C., are in need of your help in order to continue the rural health care concept that was started in 1973. I know you are familiar with our concept because of your recent meeting at Eldridge, Iowa, and your conversation with Dr. Paul Koob and Mrs. Joan Wentworth, F.N.P.

I am writing this letter as the founder of the concept in 1973, the author of the HURDA Grant for Wheatland, and the present manager of the Medical Associates of Maquoketa. The copy of the enclosed letter from the American Academy of Physicians' Assistants is of great concern to us.

It is inconceivable to me that the federal government could fund a training program for Family Nurse Practitioners, which included free tuition, room, board, and a monthly stipend for one year, and now not recognize them under federally funded programs such as Medicare and Medicaid. The entire program's education was geared for the F.N.P. to operate in a rural clinic without a physician on the premises. A physician's presence on the premises at all times, as required by the enclosed letter, would destroy the concept of extending medical care to communities who are in need, but cannot afford a full time physician.

The HURDA Grant received for the Wheatland clinic was based on the need for a new method of providing medical care for needy communities. One of the requirements of this grant was the use of the Physician Extender concept. This again is in direct conflict with the enclosed letter.

We are both aware that the day of a physician living and practicing in communities of 1000 to 2000 population is long past. Physicians must drive long distances to hospitals, cannot be available in the offices when emergencies arrive at the hospital, they leave the town without medical coverage when they return to school for required post-graduate education or for needed vacations. Within a short time, they usually leave the community for a practice that offers them the time off, vacations, and more reasonable hours.

We believe the answer for these problems lie in the concept of a central group of physicians and physician extendors who are willing and capable of properly using the satellite concept and the physician extendor program. We have now had a functioning model for three years at the Wyoming site. It not only extends general medical care to the community but also brings specialist consultation to the community which would not be possible under any other program.

A third concept which you may not be aware of has developed from the satellite concept. Because of the increased population coverage based in Maquoketa, we have been able to attract specialists to Jackson County Hospital on a regular consulting schedule. At the present time a Board certified psychiatrist spends one-half a day a week at our hospital. A Board certified cardiologist spends one-half day a week at JCPH, a Board certified orthopedic surgeon is present one-half day a week, and two board eligible vascular surgeons spend the equivalent of one day a week in Maquoketa. At the present time, I am in the process of talking to two Board certified eye-ear-nose-throat specialists about starting a specialty consultation clinic at our hospital. There are definitely more programs available in the future if we have the patient volume and continue to expand our rural satellite concept.

If the Health, Education, and Welfare law is enforced, this will definitely end the concept in which both of us are interested. I feel this would be a tragedy for the communities now being served and the communities that could receive medical care if the concept were allowed to flourish.

The letter enclosed has given us great concern. We are not sure if we should continue to sponsor our present programs if the end result will be a violation of the

federal laws. Your ideas, comments, and help are urgently needed for us to continue our programs.

I will be available at any time or any place if you feel I can be of assistance in keeping this program viable.

Sincerely,

Dr. S. W. WILLIAMS, Jr., *Chief-of-Staff.*

Enclosure.

AMERICAN ACADEMY OF PHYSICIANS' ASSISTANTS,
Arlington, Va., October 22, 1976.

DEAR ACADEMY MEMBER: The Academy has learned that Medicare intermediaries have been instructed to perform audits of medical practices which employ physician assistants. The only purpose of the audit is to determine whether services rendered by physician assistants are in keeping with the intent of the federal regulations. Therefore, there is no need to be alarmed. I am writing to advise you of the federal regulations regarding Medicare payments for services rendered by physician assistants.

A Medicare New Bulletin, outlining physician assistant services for which Medicare can make reimbursements, states "... a new category of allied health personnel, known by various identifying titles (i.e., physician's assistant, medical speciality assistant, medical services assistant, MEDEX, clinical associate, Flexner (surgical assistant), nurse practitioner, etc.) are being trained under various programs to assist or act in the place of the physician. Services performed by these physicians' assistants in the physicians' offices or in satellite offices include not only services ordinarily performed by the physician's nurse or other office assistant (e.g., taking blood pressures and temperatures, giving injections, changing dressings), but also services heretofore ordinarily performed by the physician himself, such as routine physical examinations, minor surgery, assistance in major surgery, setting casts on simple fractures, reading X-rays, and other activities which involve an independent evaluation or treatment of the patient's condition."

"Basically, there is no provision under Part B Medicare which authorizes coverage of services of physician assistants as independent practitioners. The only basis for covering their services is as services furnished "incident to" a physician's professional service. To meet the requirements of the "incident to" provision, the services must be of kinds that are commonly furnished in physicians' offices and are commonly included in the physicians' bills. This limits coverage of services by nurses and other assistants that are commonly furnished as a necessary adjunct to the physician's personal in-office service. Thus, the performance by a physician assistant of services which have been traditionally reserved to physicians cannot be covered under Part B Medicare."

"A physician may render a personal, identifiable 'physician's service' which is covered, even though payment could not be made for the same service if rendered by the physician's assistant. For example, an office visit charged by the physician for a visit in which non-covered services were rendered by a physician's assistant may be reimbursed if the physician himself sees the patient at the time of the visit and at that time also makes an independent evaluation of the patient's condition and of the course of treatment initiated or recommended by the physician's assistant."

The Medicare News Bulletin goes on to say that "services and supplies (including drugs and biologicals which cannot be self-administered) are those furnished 'incident to a physician's professional service' of kinds which are commonly furnished in physicians' offices (or physician-directed clinics) and are commonly rendered without charge or included in physicians' bills. (Certain hospital services are also covered as 'incident to' a physician's services when rendered to outpatients. Payment of those services is made under Part B to the hospital on a reasonable cost basis by the Part A intermediary.)"

The Medicare News Bulletin defines "incident to a physician's professional service" as being "those services or supplies which are furnished as an integral, although incidental, part of the physician's personal, professional services in the course of diagnosis or treatment of an injury or illness. In addition, the services of nonphysicians must be rendered under the physician's direct supervision by employees of the physician (Section 2050.2). This does not mean, however, that to be considered 'incident to' each occasion of service by a nonphysician (i.e., the furnishing of a supply) need also always be the occasion of the actual rendering of a personal, professional service by the physician. Such a service or supply should be considered to be 'incident to' when furnished during a course of treatment where the physician performs an initial service and subsequent services of a

frequency which reflect his active participation in, and management of, the course of the treatment. (However, the direct supervision requirement must still be met with respect to every nonphysician's service.)"

"Commonly furnished' services and supplies are those customarily considered as being 'incident to physicians' personal services' in the offices of physicians or in physician-directed clinic settings. The requirement could not be considered to be met for supplies clearly of a type a physician would not be expected to have on hand in his office, or where services are of a type not considered to be medically appropriate to provide in the office setting.

I hope that this information will be helpful to you. This is not a matter which should cause alarm; the Academy believes, however, that it is prudent *at this time* to familiarize yourself and your employing physician with the restrictions regarding payment for services rendered. Given the practice of physician assistants, the current Medicare laws are viewed as inadequate. To say the least, the Medicare laws and regulations are definitely ambiguous. The AAPA will be meeting with representatives of the Bureau of Health Insurance, and we will keep you advised of any developments. Your Academy is in continuous contact with the Bureau and others, to represent your interests.

Please let us know if we can be of assistance to you. We will keep you informed.

Best wishes.

Sincerely,

DONALD W. FISHER, Ph.D., *Executive Director.*

CENTRAL IOWA HEALTH SERVICES, INC.,
October 18, 1976.

DEAR SENATOR CLARK: Please find enclosed herein the statement made at your recent hearing on rural health by Dr. Paul From, M.D., who is the chairman of a joint venture group of physicians who are in the process of implementing a more efficient delivery system for health care in the central Iowa area.

I feel that the system that the doctors in the urban area of Des Moines and the Centerville physicians are creating is an exciting and innovative plan whereby patients living in remote areas will be afforded the same care as those in the cities.

As I understand it now, the rural health services grants only allow a limited amount of funding for a telecommunications system, which I would like to bring to your attention as you and your committee strive to develop new legislation.

Doctor From and his group would be available for testimony before your committee if further hearings are necessary for the development of new approaches in the delivery of health care in rural areas.

I want to express my appreciation for your kind reception of Doctor From and his ideas. As you may know, he is one of few certified cardiologists in the state of Iowa, and he has been a leader in the medical community to develop experimental programs in the delivery of medical care to keep costs at a minimum.

Sincerely yours,

A. JUNE FRANKLIN, *Acting Director.*

Enclosure.

MERCY HOSPITAL,
Des Moines, Iowa, October 18, 1976.

DEAR SENATOR CLARK: Southern Iowa, as we have learned this morning, is one of a number of medically depressed areas within the state. There appears to be very little hope of improving the situation of medical manpower in this area in the near future.

In late 1975, a number of physicians in Centerville asked Sister Mary Gervase, the administrator of Mercy Hospital in Des Moines, and Chairperson of the St. Joseph Mercy Hospital Board of Directors in Centerville for help.

These physicians stated the hospital facility in Centerville is not the kind that they wanted, and that they would not be able to utilize that particular facility properly. They really wished to develop a connection with a Medical Center and a group of specialists. It was their feeling that their patients were going all over the country for medical help, follow up was too difficult with a widespread referral area, and that rural Iowa did not have equitable care to people in larger cities and this was not fair to those people. Comprehensive medical care was not being developed by the present referral system. Sister Gervase asked in whom they might be interested, and Dr. M. Parks mentioned Dr. Paul From and suggested that Dr. From be the organizer for the entire group.

Various discussions followed beginning on December 21, 1975 and from these discussions it became apparent that for a more efficient delivery system for health care for the Centerville area itself a tele-communications system or some system utilizing modern technology would need to be developed. Certainly, this would help solve the Centerville problem, but not necessarily for all the entire problem of the State of Iowa, as concerns rural health problems. If a modern technological system were not developed, there would be too much delay in receiving a report, and this would be too costly to the patient because reports were not promptly received. In addition, a plan must be developed that would encompass total health care rather than handling of one referral problem only.

It became clear that this system would then provide a reduction in cost factor, would help in recruiting at a rural level because of an intimate association with urban specialists, would allow for rapid results of all referrals, would give equitable health care in the rural area at a cost effective level, and would allow on-going education of the physician and paramedical specialist.

For the past two years I have been interested in problems of alternate methods of health care delivery and many people had looked to me for leadership in attempting to develop alternate methods of health care delivery. The Board of Directors of the Centerville Hospital looked to their physicians and to me for leadership.

Mercy Hospital, with which I am most closely associated, in Des Moines, had several experiences with Mr. David Neugent and his staff at Blue Cross/Blue Shield in experimental programs, and because Mr. Neugent and his staff had been quite innovative in these programs, I looked to Mr. Neugent for consultative help in developing this project. I knew Blue Cross/Blue Shield in Iowa was one of the few Blue Cross/Blue Shield programs in the country that keep administrative costs at a minimum for the Medicare/Medicaid program, had a wealth of talents, was extremely innovative, and was highly regarded at our own community level for efforts to contain health care costs. Thus, it seemed natural for me to seek their help.

We developed a plan revolving about a joint venture. The name of the organization is the Central Iowa Medical-Surgical Associates. At this moment 27 physicians belong to this venture, and 4 more will be added so that at least 31 physicians will be members. This venture will handle both the office and hospital practice of medicine as we know it today. The actual system is now in operation but is using the old and antiquated methods of communication and record keeping that is relied upon by physicians in hospitals.

The MITRE CORPORATION was asked for help, and we have met with Mr. Art Bennett of Mitre Corporation. Northwestern Bell Telephone Company has offered its services to help with this project in any way possible.

The Governor of the State of Iowa has expressed interest in the project, especially the utilizing of Emergency Transportation System via National Guard helicopters for those in Centerville and the Lake Rathbun area. Projected population on week ends and during the summer for the Lake Rathbun area is 100,000. Also, the Governor is very interested in rural health care problems in Iowa.

Satellites have already been developed because of this venture. One is open in Moulton and one is being developed in Moravia, and another is contemplated for Seymour, Iowa. An LPN staffs the satellite in Moulton and doctors visit there two afternoons per week. Physician extenders will undoubtedly be utilized at the appropriate time, but with this particular system there can be close supervision via Tele-communications network of the physician extender which is not possible with other methods of present utilization of the physician extender.

Many other rural areas are now looking to us for help, and particularly the cities of Osceola, Corydon, Leon, Creston, Albia and many others.

I believe that if we can work out the mechanisms for such a system we could, with the method, help enhance the capability of quality care, and with additional volume, look for even more cost effectiveness and cost containment. Health care costs could decrease with this system as the types of hospitals must change in the future, satellites develop, and other innovative methods be developed to handle the problems. Cost effectiveness such as a tele-health or tele-communications network has been well documented by the MITRE CORPORATION.

I would envision a computerized medical record with computer kept at the site of origin and at this time, do contemplate that we would utilize Augmented Narrow Band Telephone wires for black and white television, transmittal of x-rays, transmittal of electrocardiograms and electronic stethoscope sounds, transmittal of microscope slides and fiberoptic visualization, transmittal of pulmonary function data and blood gas data, to name but a few. In addition, this system would allow for direct visual communication between the family physician and the referring specialist at any time in the day or at night if the home

is utilized, and would be an excellent system for on-going physician education and paramedical education within the venture itself.

I believe that with the development of such a system, within a period of three up to at the maximum five years, a tremendous change or improvement could be brought about in the problems of rural health care in Southern Iowa. I believe such a system would become a model for solving many problems in rural health care, and would certainly, in the long run, be a very cost effective method for reducing health care costs while maintaining and improving quality medical care.

Sincerely,

PAUL FROM, M.D., *Chairman, Joint Venture Group.*

ROBERT F. MCCOOL, M.D.,
THE CLARION CLINIC,
Clarion, Iowa, November 8, 1976.

DEAR SENATOR CLARK: Our county of 17,000 has 11 practicing physicians, including one surgeon. Our Clinic is composed of four G.P.'s who have about 18,000 on our active files.

We work hard, but with excellent roads and good specialists within 50 miles, we feel we do a good job in our rural setting. Someone is always on call for emergencies.

Some of the complaints may come because at times our patients may have to wait longer than they want. This would not be cured by any increase in doctors.

A poorly-trained and poorly-motivated (money!) doctor in our small towns is much more dangerous than none at all, because the skill of diagnosis is about 90% of our value to our patients.

To miss a few surgical abdomens or fractures would seal his door, because the potential patients will not go to him.

A good physician should need no subsidy. None of us did when it was a lot harder to make a living. We came because we had families to support and we wanted to practice in a small town. We were cocky enough to think we were good enough doctors to make it on our own.

I feel that manpower executives have made regular visits to the nursing homes mandatory, anywhere from once a month to three times a year.

A good nurse supervisor should be able to make recommendations when patients have to be seen.

After all, most of our senior citizens who live privately go to the doctor when they feel it is necessary or for continuing care as recommended by the physician.

So many nursing home patients have problems such as senility, difficulty in getting around, etc., which are really not medical problems, and yet these are the very ones we must see.

For us physicians to say, "Hello, how are you?", poses an enormous expense to all of us.

Let us use some common sense in the care of these older people—once-a-year checks would be enough for 80% of these folks.

Sincerely,

ROBERT F. MCCOOL, M.D.

MORNINGSIDE COLLEGE,
NURSING EDUCATION DEPARTMENT,
Sioux City, Iowa, November 11, 1976.

DEAR SENATOR CLARK: Several weeks ago I received your letter regarding the rural health care hearings you have since conducted in Northwest Iowa. I was unable to attend the session in Menville October 17 due to hospitalization and health problems I have incurred this fall.

Although I was unable to attend the meeting I followed the report on the news and in the Sioux City Journal. The article in the Journal gave good coverage to your hearing in Menville and it appears that you had a good session. However, I was somewhat concerned over the fact that in the Journal article, nurses were not mentioned as a source of primary care for rural areas. I am very much in favor of, and feel that many nurse practitioners are very capable of conducting clinics in areas where medical care is in short supply or nonexistent. In fact, I believe that there are professional nurses who have not had practitioner preparation that are more knowledgeable regarding the provision of primary care than some of the physician's assistants that are being turned out in some states of our nation.

The revised Nurse Practice Act of Iowa that was enacted in the spring of 1976 does allow nurses to practice in expanded roles in Iowa and hopefully this will

begin to occur as more and more of our older rural physicians retire and there is a shortage of physician replacements for them. In Woodbury County we lost our last rural physician in the fall of 1975 and the people from rural Woodbury County are now forced to travel to physicians in adjoining Plymouth or Monona Counties or into the city of Sioux City for primary health care. This is a real hardship for some people for various reasons, including the difficulty of traveling the distances required and the difficulty of getting accepted by a physician in Sioux City; consequently a higher number of people in rural Woodbury County are presently having more problems finding the primary health care they need now than they were a year ago.

Thank you for sending a copy of the speech you gave before the Senate about the federal role in health. I was pleased to read it and find myself in agreement with it. Many of us were very concerned about President Ford's recommended budget cuts and vetos of federal funding for health care and health education programs during the last year. I feel that federal support of medical and nursing education programs is absolutely vital to our nation. The nurse practitioner training programs will hopefully result in nurses being prepared and willing to provide primary care in areas that have a real shortage of primary care providers. However, we will continue to need the financial assistance for students in first level nurse training and for programs providing this nursing education if we are to continue to turn out the number of nurses necessary to provide the many health care services that are needed by the people and especially the rural people.

I believe one alternative that should be given stronger consideration in the search for a means of providing primary care in rural areas is the establishment of nurse conducted clinics for primary health care, especially for the aged and children. However, federal or state financial assistance may be necessary and should be considered for the establishment of these clinics.

Thank you for the invitation to your hearings and your letter requesting comments on health care service for rural areas. I strongly support the fine work you have been doing and your strong interest in health care and education for the health professions. Keep up the good work!

Sincerely,

MARGARET SOKOLOWSKI,
Chairman, Nursing Education Department.

BLUE CROSS, BLUE SHIELD OF IOWA,
Des Moines, Iowa, November 15, 1976.

DEAR DICK: Thank you for the opportunity to contribute to the discussions you have been conducting on rural health care.

Unfortunately, I was not able to arrange my schedule to attend any of your recent hearings in Iowa, but I am pleased that Blue Cross and Blue Shield of Iowa was able to have representatives at several sessions. The reports I received were highly complimentary about your conduct of the sessions and your strong personal commitment to quality health care for our rural citizens.

Blue Cross and Blue Shield of Iowa share your concern for cost effective health care in our state's rural areas. Our effort to provide leadership and professional expertise in Iowa's first Health Maintenance Organization in Bloomfield is an example of how we view our role. In addition, we have attempted to serve as a catalyst in several other projects in our state. One of the most promising programs has been the Central Iowa Medical-Surgical Associates project between Centerville physicians and a group of referral physicians in Des Moines. I understand that Dr. Paul From testified on this matter at your hearing in Grimes. Since you already have detailed information on this subject, I will not repeat Dr. From's detailed account. I would like to point out, however, that we at Blue Cross and Blue Shield are convinced that the health care problems of rural areas can be solved with careful planning and cost conscious use of modern technology. The utilization of sophisticated communications networks to link rural area physicians with the medical skills of urban areas is definitely a method which needs further exploration.

We are convinced that innovative programs such as these deserve our support and investment and offer great potential for the future.

If I can be of further assistance, please let me know.

Sincerely,

DAVID S. NEUGENT,
*Office of the Chief Executives,
President, Blue Cross of Iowa.*

IOWA STATE DEPARTMENT OF HEALTH,
REGIONAL HEALTH SERVICE,
Manchester, Iowa, November 9, 1976.

DEAR SENATOR CLARK: I attended the Rural Health Hearing at Traer on October 18, 1976, and I would like to communicate some of my thoughts regarding rural health care.

First of all, I would like to acquaint you with myself. After graduating from the University of Iowa, School of Nursing, in 1972, I worked as a public health nurse in Clayton County, Iowa, for approximately 3½ years. Since March of 1976, I have been a Regional Nurse Supervisor with the State Department of Health. I serve as an advisor/consultant for nine public health nursing services in Northeast Iowa.

Secondly, I would like to emphasize my belief that deliverance of health care involves the *whole* health team, such as (but not limited to), D.O., dental hygienist, dentist, M.D., nurse, nutritionist, physical therapist, etc. To some degree we are dependent upon each other, but we all have independent functions also. In providing adequate and efficient health care, we need to consider the whole team.

Since public health nursing is my area of expertise, I would like to explain the services that can be provided by public health nurses.

In the area of homevisiting, public health nurses provide skilled nursing care of the sick. In these situations, the nurse is using his/her skills to assess total patient and family situation, perform skilled procedures, teach regarding condition, procedures, diet, medications, etc. Teaching is very important because we strive to develop maximal independence of patient and family. We are covered by physicians' orders and communicate frequently with the physician re: patient status.

Public health nurses also work towards preventing and controlling communicable disease. In this area we teach regarding importance of immunizations, identification, control and treatment of communicable diseases. The nurses serve as liaisons between the Iowa State Department of Health and the community in this area. Every public health nurse is currently heavily involved with the influenza vaccination program in addition to maintaining their other responsibilities.

Public health nurses also provide general health supervision in such areas, but not limited to, pregnancy, child care, nutrition, growth and development, accident prevention, and family planning.

Another area of public health nursing is community involvement. Examples of this are: newspaper publicity regarding health topics, hypertension screening clinics, diabetic screening clinics, prenatal classes, addresses to groups re: various aspects of health, communication and coordination with other agencies and services.

Public health nurses are expanding their training and roles to include participation in well elderly clinics and well child clinics. The nurses are screening well individuals and are referring individuals with abnormal results to the physicians. These clinics are covered with physicians' orders. Besides receiving thorough screenings, much teaching and preventive activities take place.

It is evident that there are a wealth of areas public health nurses can be involved with the deliverance of health services to the residents of Iowa. There are ample nurses prepared for public health nursing positions. However, the currently existing agencies are grossly understaffed. Presently, there are 103 agencies in Iowa providing public health nursing services—(83 county agencies, 3 combination agencies, 13 voluntary agencies, 2 city agencies, and 2 hospital-based agencies). There are a total of 359 public health nurses employed in these agencies. According to nationally accepted recommendations, there should be one public health nurse per 3,000 population when providing generalized nursing services. Using statistics from the 1970 census, Iowa currently has one public health nurse serving roughly 8,000 people. We need to expand our public health nursing staff nearly three times to adequately provide generalized nurses services.

Needless to say, we presently need to limit our programs, in spite of the need, because there just isn't enough staff to handle what *could* and *should* be done. Our problem is that of funding. For example, county public health nursing services are funded through their counties' general funds, which are limited. Some assistance is provided to some agencies in the form of federal funds (314D funds and maternal and child health funds); however, the federal funds are limited. There is a need for expansion but no funds with which to expand. Seventy-two agencies are certified to bill Medicare and other insurance companies for skilled nursing care. However, up until now, this hasn't been able to support these agencies.

I feel the legislature needs to look closely at the services public health nurses can provide when considering deliverance of health care to Iowans and the allocation of funds.

Sincerely,

(Mrs.) CAROLYN A. BUSHAW, R.N.,
Nurse Supervisor.

AMSA RURAL HEALTH COMMITTEE,
UNIVERSITY OF IOWA COLLEGE OF MEDICINE,
Iowa City, Iowa.

ASSESSING RURAL HEALTH CARE IN IOWA

Medical students at the University of Iowa Medical School are becoming actively involved in exploring the status of health care as it is and will be practiced in the coming years in rural Iowa. The local chapter of AMSA has organized a Committee on Rural Health that is pioneering an attempt to increase communication between future physicians and consumers of rural health care. Specifically, they wish to increase the Medical students awareness of the needs and expectations of health consumers, and likewise to increase consumer understanding of the expectations of medical students for a practice in Iowa.

To accomplish this, Iowa AMSA (American Medical Student Association) is funding an independent student project which will send medical students into rural Iowa communities to informally exchange ideas and information. Our goals:

- (1) To increase the medical student awareness of the status of rural health care.
- (2) To increase consumer awareness of the needs and expectations of medical students as future health care providers.
- (3) To increase both consumer and medical student awareness of the prospects for future health care in rural Iowa; this might include a discussion of alternatives and supplements to traditional medical practice (e.g. nurse practitioners, physician's assistants, regional health care).
- (4) To serve as a liaison group between consumers, planners, financiers, and educators of health care.
- (5) To encourage and broaden medical student interest in rural health care.
- (6) To offer recommendations to various health planners, financiers, and educators of health care.

Will our being medical students offer any advantage in talking to communities? Yes, we think, because as students we have few commitments or personal investments in the present health care system, and as a result, will be more open to an exchange of ideas. Furthermore, we will be a part of the health care system of the future and are personally interested in helping shape it in a manner suitable to all. In addition, medical students are presently being looked to by citizens of rural Iowa to solve their health care needs; as such, their suggestions and appraisals may gain more credence than (or at least reinforce) the often unwelcome outlook of health planners. No, because students of other health care professions are equally qualified. They are not being included at this time only for financial and organizational reasons.

It is presently foreseen that the community meetings will be run by first and second year medical students (and any upperclassmen that may have the time) most likely during the three week Christmas break. Hopefully these meetings will not only attract community leaders, but also any others from the general community who are interested. It is hoped that the meetings would allow:

- (1) Students to compile a list of specific health care problems and questions of the community.
- (2) Students to express their own expectations for a practice of rural health care.
- (3) Students to present plans now being-suggested by health care planners, financiers, and educators concerning rural health care.
- (4) Students to become increasingly aware of rural health needs—on a first hand basis.
- (5) Communities to become increasingly aware of the future of rural health care.
- (6) Communities to gain insight into their own health care and recruiting problems, and to become familiar with those resource people who might be of particular help.

A community or communities with a population of less than 10,000 will be selected by student choice, and may likely fall within a close geographic proximity

to a student's home. These communities will then be approached through letters to local community newspapers, physicians, and any community organizations concerned with local health care or health manpower recruitment. These letters will explain the goals and expectations of the proposed meeting, emphasizing that the student planning the visit is not expressing an interest to practice in the community, but rather is expressing an interest in the status of rural health care in general.

Preparation of the medical students for the community visits will be accomplished in two ways. First a series of three informational sessions is being planned for successive Tuesday evenings beginning November 23. They will begin at 7:00 p.m. and last no longer than one and one-half hours. These sessions are open to all, not just those wishing to make a community visit.

A rough format is as follows:

Background in rural health care delivery.

Assessment of need.

Survey of current issues.

Roles played by government agencies, health planning groups, medical societies, legislative bodies, and medical educators in the financing of and planning for rural health care delivery.

A focus on Iowa—present status alternatives.

Preparation of the student for a community survey.

Secondly a syllabus on rural health care including most of the facts and data provided in the evening sessions is being prepared. This can be used by the student during the community presentation. Each student will be given an honorarium of \$10.00 plus expenses for each community visited. Then in January all the data and impressions gathered by the medical students will be brought together in a summary report. A copy of this report will be sent to each community visited plus such planning groups as the three state Health Systems Agencies, the Iowa Medical Society, the University of Iowa Medical School, and state and federal legislators. Communities having specific questions or problems will receive additional information.

Providing the background information for the lecture series and syllabus will require the involvement of many. Included at present are: Bruce Brenholt and Roger Tracy, Dean's Office of the College of Medicine; Doug Cox National AMSA Foundation; and Robert Wallace, Department of Preventative Medicine and Environmental Health. Others who might become involved are health planners (Dr. John Tyrrell M.D.), private foundations (Interstudy, Robert Wood Johnson), other health providers (physician assistants, nurse practitioners), and physician groups (Iowa Medical Society).

Those of us on the steering committee for this project are very excited by the interest expressed by a sampling of medical students, the willingness of other groups to help, and the possibilities of community involvement. Planners for rural health care must be responsive to the needs and input of all consumers. This responsiveness depends upon increased awareness. And increased awareness is our business.

GEORGE SCHOEPHOERSTER.
DAVID LOXTERKAMP.

IOWA VETERANS HOME,
Marshalltown, Iowa.

DEAR SENATOR CLARK: It is hopeful to hear of the acceptance of the clinics in Tama County. However, most of the discussion this morning has been focused on physicians and physician extenders. The assumption I have been hearing is that medical care—health care. While medical care is *one* component of health care, it is not all inclusive; the focus of medical care is curing.

The need for persons to care for themselves is addressed by Nursing Care, in addition to helping the person cope with the assaults on health by illness, and to do those things which promote health. Nursing has a role in health care that complements, but is not dependent on medical care except for that area of carrying out the medical regimen.

Barriers to nursing services being available to persons in rural areas include lack of a mechanism for financial reimbursement through third party sources unless connected with a physician and lack of recognition unless an "extender" of physicians services.

My experience has been primarily in working with the elderly. Over 95% of the elderly live in the community, and in Iowa a large percentage of the elderly live in

rural areas. As Jerome Hammerman pointed out in the March, 1974 *American Journal of Public Health*, many of our efforts and monies go to acute treatment or nursing home care. Of the other services he identifies as necessary in a comprehensive and systematic health care system, nurses could be instrumental in each area. He includes assessment of health; education to preserve health; appropriate preventive and outreach services; physical, mental, social and supportive services necessary to maintain or restore health; rehabilitation; and maintenance and long term care when disability occurs.*

A survey conducted by a colleague and myself this summer in southern Iowa indicates that even in areas where substantial services have been developed such as meals on wheels, congregate meals, transportation services, the above mentioned services are not apparent. Perhaps the most important incentive to development of these services would be third party reimbursement for nursing services.

ELIZABETH WEITZEL.

DICKINSON PUBLIC HEALTH NURSING SERVICE,
Spirit Lake, Iowa, November 9, 1976.

DEAR SENATOR CLARK: Schedules and distances made it impossible for me to attend any of the Iowa Hearings. I do appreciate your concern for rural health delivery and encourage you to work toward extended programs of preventative health care as well as crisis health care.

I feel that continued funding through 314D (Maternal & Child Health Funds) for Public Health Nursing is of great value. Additional funding for in home preventative programs for the elderly would also be very valuable. In a rural county such as I serve, Public Health Nursing and Home Health Aide services make it possible for many elderly persons to remain in their own homes rather than be placed in custodial or nursing homes.

Staff time is not available for the number of service requests received and funding from various grants sources for those persons that aren't covered by Title XIX is intermittent. Many appropriate care areas are not covered under Medicare.

An example of the service in our County: Five Home Health Aides supervised by one nurse served 42 persons this last month. A total of 710 hours.

We find persons who are able to continue in their own homes often are more alert mentally than if institutionalized and in fact, if hospitalized for acute illness may become confused and then become more alert when returned to their homes. The cost of care in the home is usually markedly less.

Thank you for your interest and concern.

Sincerely,

Mrs. VIVIAN C. LYNN, R.N.,
Dickinson Co. Public Health Nurse.

STATEMENT OF RURAL AMERICA

We are grateful to Senator Clark for inviting us to take part in this investigation of rural health care problems. As we were unable to attend the October hearings, we would like to take this opportunity to submit a written statement addressing some of the critical rural health care issues.

Rural America is a national membership organization of people concerned with the whole range of rural problems and human needs. Our membership is made up of people from all walks of rural life, and others associated with a variety of public interest organizations. Our members are especially concerned with the crisis in rural health care.

Let us begin with a brief sketch of the health conditions of rural America. Nowhere in the United States is the need for an improved health system more pressing and nowhere is it less adequate than in rural America. From the standpoint of nearly every measure available, the status of health and health care of people in small towns and rural areas is poor.

HEALTH CONDITIONS IN RURAL AREAS

There are several specific examples which should leave little doubt about the crisis in rural health. Figures prepared by the U.S. National Center for Health

*Health Services: Their Success and Failure in Reaching Older Adults, pp. 253-256.

Statistics show that the infant mortality rate in rural areas is significantly higher than in urban areas, with the rate for the rural nonwhite and poor population almost twice that of the white urban population. This gap, measured by the number of preventable infant deaths, has been increasing rather than declining in the last ten years.

If we examine the maternal mortality rate, we find a similar situation. While women in rural America make up only 20 percent of all women of childbearing age, they account for 50 percent of all maternal deaths in the country. The message of these figures on infant and maternal mortality is quite clear. For both, rural America offers a more hazardous environment than urban America.

Work related death and disability in rural communities has long constituted a major health problem, and has only recently begun to attract serious national attention. It should come as no surprise, however, particularly because traditional rural occupations such as mining, timbering, and agriculture are among the most dangerous to working people. And although our system of collecting information concerning work related injury is inadequate, particularly with regard to such rural problems as farm accidents and the effects of pesticides on humans, there is growing evidence that the mortality rate for rural workers is almost double that of their urban counterparts.

Some additional data on the existing health problems of rural Americans is also worth reviewing. According to a report compiled by the U.S. Department of Agriculture Economic Research Service, data on chronic health problems indicate that they are higher for all income groups in rural than in urban areas. Coupled with a higher incidence of chronicity among low-income people, government figures show that 1 out of 6 rural residents, as compared with 1 out of 10 residents from large metropolitan areas is affected by a chronic condition that limits activity. Within rural areas this differential is greatest among middle and older age groups and among farm families.

Another serious health problem confronting the rural poor is malnutrition. A study conducted by the National Council on Hunger and Malnutrition and the Southern Regional Council indicates that approximately 26 million Americans cannot afford to purchase an adequate diet, and over 11.2 million of them are receiving no assistance through the Federal food program. It is estimated that the majority of these people live in rural America.

These, then, are some indicators of the status of health in rural America. It is not a static situation, it is changing. In fact, in this century, we have managed to reverse the traditional relationship between urban and rural areas as far as the public's health. Today, on the basis of most indicators, rural America is far less healthy than the more urbanized part of our society.

For these reasons, we appreciate Senator Clark's commitment to improve health care in rural areas and were especially pleased that the Senate Rural Development Subcommittee sponsored rural health care hearings. We agree with the Senator that the Congress has responded to the rural health care situation, but we feel that the response has been limited in relation to the need.

COMMUNITY HEALTH CENTERS

The Community Health Center program is one example of the Congressional response to the nation's health underserved areas. It is not, however, a response to critical rural health care problems. Let us examine the figures. According to DHEW, the latest final program data available are for 1975.

In 1975, Congress put 197.2 million dollars into 164 community health centers, which include neighborhood health centers, family health centers and community health networks. The average grant for operating funds was close to 1 million dollars per health center. This money has gone largely to metropolitan areas. Of the 164 centers funded under this program, 123 or roughly 75 percent of them are located in urban areas. Only 41 centers, or one-fourth are located in rural areas. DHEW hopes that the Centers will eventually become self-sufficient, but there is no self-sufficiency requirement in the grants.

According to data recently compiled by the DHEW Bureau of Community Health Services, almost 50 percent of all rural Americans live in medically underserved areas with comparable physician-to-population ratios worse than one for every 4,000 residents. Clearly, the 41 community health centers which are located in rural areas do not begin to address the problem. Although the exact figures for 1976 will not be available until December, no significant changes in the urban/rural ratio for the community health center program are indicated.

RURAL HEALTH INITIATIVE

In 1975, the Bureau of Community Health Services in DHEW created the Rural Health Initiative program to help deal with the crisis in rural health care. Under this program, grants of up to \$200,000 are available to communities to cover the operating costs of primary health care centers in rural areas with critical health manpower shortages. According to the terms of the grant, the projects are expected to become self-sufficient within three years.

At present, 191 rural areas have been awarded grants for a variety of primary health care projects under the RHI program. DHEW has projected that in fiscal year 1977, the Bureau of Community Health Service will put approximately \$44.7 million into a total of 350 RHI projects.

This program was originally organized by DHEW utilizing existing funds from a variety of on going programs, such as the Community Health Center program, the Migrant Health Program, and the Health Underserved Rural Areas program. For fiscal year 1977, Congress has specifically designated funds for the RHI. In this sense, Congress is responding to the rural health need. However, a comparison of the Community Health Center Program and the Rural Health Initiative Program indicates that the RHI is a poor stepchild of its largely urban counterpart. The Rural Health Initiative awards grants of approximately one-fifth the average size of grants awarded to the Community Health Centers. More significantly, the RHI grants have a self-sufficiency requirement not present in the Community Health Center grants.

The self-sufficiency requirement will spell disaster for many of the rural health facilities recently funded under the Rural Health Initiative program. Forty percent of the nation's poor live in rural America. Generally, they cannot afford to pay the clinic's standard charges. Further, the clinic's charges do not usually reflect the actual cost of services, especially in the first few years of operation, when the clinic's expenses are greater.

In many instances, Rural Health Initiative projects will require at least 70% third-party reimbursements to become self-sufficient. However, rural residents are less likely to be covered by private health insurance plans, and the plans they do have are less comprehensive than those of most urban residents.

MEDICAL/WELFARE PROGRAMS

Unfortunately, public programs such as Medicaid and Medicare have failed to fill the gap in this private health insurance coverage. Eligibility for Medicaid is tied to Federal welfare categories (aged, blind, or disabled, or members of families with dependent children where one parent is absent, incapacitated or unemployed). Many of the urban poor qualify under the one-parent requirement. However, most rural people are part of two-parent families with low incomes from agriculture, small manufacturing or service jobs. The majority of the rural poor are therefore excluded from the Medicaid program, due to greater family stability.

Medicare also discriminates against rural people. A high proportion of rural residents are elderly and many of them are poor. However, the Medicare customary fee system pays rural physicians significantly less than is paid to their urban counterparts performing similar services.

Another serious deficiency in the Medicare law relates to the restrictions applied to the reimbursement of services rendered by nurse practitioners staffing rural clinics. Under the present law, the services of nurse practitioners and other physician extenders are reimbursable under Medicare, only if these services are provided under the direct personal supervision of a physician. A great many rural health clinics are in areas where, because of limited medical resources and the isolated character of the community, physicians services are generally inaccessible. In such areas, rural health clinics rely almost exclusively on physician extenders. The inflexible nature of the direct supervision requirement penalizes rural health facilities which do not have access to the services of a physician on a full-time basis.

An additional problem confronting the Rural Health Initiative projects and other primary care facilities operating in rural areas is that many of them do not qualify for cost-based reimbursement under Medicare. This means that the individual or organization providing medical care is only reimbursed by Medicare on the basis of fees charged, rather than the actual cost of the services.

Cost-based reimbursement under Medicare has been, by Federal law, restricted to recognized "providers of service," such as hospitals, home health agencies and nursing homes. Other facilities were reimbursed on the basis of fees charged, or the "usual and customary charge" for that service in the same area, whichever

is less. If the prevailing charges in a rural area are low, the amount that the clinic can collect from Medicare will also be low, regardless of the cost of the primary care program during its start-up years.

Several years ago, Medicare agreed to reimburse on a cost basis certain ambulatory care clinics which had received Federal funds as a means of cutting back DHEW grant support for these programs. At the outset this program was restricted to a very limited number of clinics, primarily neighborhood health centers, the majority of which are located in urban areas. As a result of negotiations between the Bureau of Community Health Services and Social Security (Medicare), the Secretary of DHEW agreed in March 1975 to expand the program to include a variety of other clinics, including several rural health facilities. Clinics which have changed to cost-based reimbursement have indicated that this procedure has meant a 40% increase in the amount they collect from Medicare.

Unfortunately many rural health facilities are still unable to qualify due to the criterion of "physician-directed." This criterion eliminates many rural primary care facilities which are principally staffed by nurse practitioners and other types of physician extenders. In most cases the services rendered are under the general supervision of a physician who works at the clinic 8 to 20 hours per week. These clinics provide excellent medical care, and it is often the only care available to residents in the area.

In summary, government programs have created a variety of primary care facilities in rural areas funded through Federal grants, but have failed at the same time, to modify Medicaid and Medicare programs to facilitate the reimbursement of the services rendered at these facilities. In the case of the Rural Health Initiative, imposition of a self-sufficiency requirement compounded by innumerable reimbursement problems will undoubtedly force many of the clinics to close at the end of the three year period.

There is a glaring need for national legislation to greatly expand financial support for Rural Health Initiative projects and other primary care clinics in rural areas. These facilities often serve the rural poor and in the absence of a national program for financing health care, many of these clinics will continue to need Federal grant support for operating funds. As long as it is evident that a clinic is using its funds honestly and efficiently to deliver quality health care, and is making every effort to maximize third-party reimbursements, it should receive Federal support without the threat of withdrawal after a three year or other designated time period. The self-sufficiency requirement imposed on health clinics serving the rural poor should be eliminated.

RECOMMENDATIONS

There is also a need to modify the Medicaid and Medicare programs so they respond to rural needs and provide needed financial support to rural health facilities.

Changes should include:

Revision of Medicaid programs to include low-income two-parent families regardless of employment or welfare status. All states should be required to cover the services of rural health centers and the medically needy.

Medicaid and Medicare programs should be amended to provide for reimbursement of rural physicians on the same basis as urban physicians within the State.

These programs should be modified to provide for reimbursement of nurse practitioners and other physician extenders whether or not a physician is physically present at the time the service is provided.

Rural Health centers should be designated as "providers of service," under Medicaid and Medicare. As such these clinics would be eligible for direct reimbursement based on average expenditure levels for all persons covered by Medicaid and Medicare in the State,

Nonetheless we must recognize that current Federal and Federal/State programs, even modified to reflect much needed reform, only deal with limited aspects of the problem. These partial efforts must be supplemented by a Federal commitment to develop an adequate national system for financing health care. To be effective, such a system must contain the following elements:

It must provide for universal entitlement for all citizens;

It must be comprehensive in terms of coverage and compulsory;

It must have no barriers to service or participation, either geographic, economic, or other;

It must rely on public financing; preferably through a progressive tax on income;

It must recognize the special problems faced by rural people in obtaining adequate medical care and respond to the unique circumstances surrounding smaller, rural communities' participation in such a national system; and

It must be administered by a public agency or public corporation free of domination by either the private insurance industry, organized medicine, or other special interests, and it must be controlled by those it serves, the consumer.

We recognize that a national system for financing health care will not automatically eliminate all barriers to adequate health services for rural people. It could not reasonably be expected to. The maldistribution of health professionals continues to be a major problem. Although between 30 and 40 percent of our national population currently resides in rural America, it is served by only 12 percent of the nation's doctors and only 18 percent of the nurses. We must examine alternatives to traditional recruitment and training of physicians and continue to encourage the maximum use of physician extenders.

However, even by improving the distribution of providers, we will not guarantee equal access to health services in the absence of the means to pay for these services. We urge the Congress to fund existing programs at adequate levels and to provide the reforms which make these programs responsible to rural needs. Moreover, we must conclude that there can be no substitute for a publicly financed, comprehensive system of health coverage for all Americans.

GLADBROOK, IOWA.

DEAR SENATOR CLARK: It is about time our government officials put a halt to all of this paper work being piled on us from all directions.

Why should the doctors (majority of them are honest, help the needy with no payment coming to them, work long hours, etc) be picked as the "whipping boy" !?!

If socialized medicine takes over in our wonderful country, people will be getting worse care—not better.

Example in Great Britain—poor health care. We were there in 1968—we saw this first hand and didn't like it. Naturally, people getting assistance like it, they think they're getting something for nothing.

What fools they be!

MRS. SCHAEFERLE.

WONEWOC, WIS., November 17, 1976.

Senator RICHARD CLARK,
Russell Building,
Washington, D.C.

DEAR SENATOR CLARK: Your request for written testimony on rural health care delivery is enclosed. Many thanks for the opportunity to respond. I am a Family Nurse Practitioner who has been trying to establish a Nursing Service Agency in a rural area of Wisconsin. I personally know of the obstacles which I touch upon in my testimony. You will hear the same story repeated throughout your hearings. I appreciate your support for our new endeavor and hope your hearings will prove effective in initiating the changes necessary for the implementation of new solutions to old problems.

Sincerely,

Enclosure.

JOSINE M. LEONARD, R.N.

NOVEMBER 17, 1976.

Senator RICHARD CLARK,
Russell Building, Washington, D.C.

The health needs of people in rural America have been documented for the past 15 years through all the data compiled by local, state and regional agencies, as well as Federal agencies. This documentation has recently been reinforced in the state of Wisconsin in the written report submitted by the Governor's Task Force on Health to its citizens. The problem has not improved but in fact, has gotten worse.

There has been a history of over-emphasized in-patient care, resulting in facility building of small hospitals. Now these hospitals face problems of economic feasibility based on occupancy rates. Methods of funding have favored in-patient care over out-patient, but neither is funded to the level where poorer counties can

afford as extensive facilities and services as rich ones. Private health insurance reinforces this imbalance. Even a whole range of out-patient services provided by nurse practitioners and other professionals are excluded from coverage. Manpower distribution and utilization has been identified as a major problem in delivery of health care services. The nurse practitioner is emerging today as a person who can be better utilized in the delivery of primary care in an ambulatory setting. The Federal Government has committed funds to the program development for nurse practitioners. This model is in operation in many rural areas throughout the U.S., Maine, Vermont, Minnesota, Kentucky, Arizona, California, etc., and is proving its effectiveness in the delivery of health care. Yet the utilization of such models is hindered by a number of forces. Financial reimbursement, through 3rd party payers makes independent function most difficult, as practicing physicians, sometimes unfamiliar with the concept resist implementation. The nurse practitioner as an innovation in delivery of health care needs acceptance and support from the medical community as well as the nursing community. The consumer population has demonstrated support of the nurse and as visibility increases utilization will also. The public is demanding health services and yet the only entry into the health care system is through the physician. Even today, in Wisconsin a nurse cannot make a referral into a hospital setting; cannot utilize laboratory services, X-ray services, ancillary services without orders from a physician. Such limitations identify the need for the development of teamwork based on mutual understanding and trust. When such a relationship exists, the comprehensive delivery of health care to the consumer is assured. This has been documented in Wisconsin through Nurse/Physician Team Program, Department of Family Practice, University of Wisconsin-Madison. The focus of this program is the development of a *team* approach to health care delivery by utilization of medical and nursing skills and mutual decisionmaking.

It also raises the issue that other entry into the health care system must be opened. Physicians in rural areas are overworked, getting older and finding few replacements. The Federal Government can still provide funding for innovative programs in delivery of ambulatory primary care. Perhaps the visibility of a Nurse Practitioner Service Agency can act as a force to open up other entry into health care besides the physician. Hospitals must also reconsider their policies which limit referrals to physicians only.

The role of the physician as sole leader of health care is now receiving a challenge. Dr. Lowell T. Coggershall, a distinguished medical educator has summarized the challenge succinctly as follows: ". . . The public generally conceives the physician to be an all-knowing professional who is responsible for and capable of providing all health services needed by people. In fact, many physicians delude themselves in this regard. However, we are coming to the realization that the health team must include persons who provide varied services to patients, families, and communities. Some are services that physicians do not know how to provide." The nurse practitioner is challenging that role of the physician. Within nursing there still is confusion as to the new independent functions the nurse practitioner is assuming.

Rural health care delivery needs health professionals other than physicians. Perhaps the nurse practitioner can be a new solution to an old problem.

DEWITT FAMILY MEDICAL CENTER,
DeWitt, Iowa, November 16, 1976.

HON. DICK CLARK,
U.S. Senate,
Washington, D.C.

DEAR SENATOR CLARK: We were all honored by your visit and I particularly appreciated the opportunity of meeting you in person on your October 19th inspection of our facility, here at DeWitt Community Hospital. Those of us in Iowa who spoke out against the Vietnam war were largely without a voice in Washington before your time, and we will always be grateful to you for your strong stand on that issue. Further, we like the reasoned and reasonable approach to other problems that you have demonstrated since, and for the benefit of us all, we hope to keep you in office for many years to come.

I believe that your visit to DeWitt Community Hospital and the Family Medical Center was timely in many ways; considering that the two problems you were concentrating on, namely attracting health manpower and financing of rural health services, have been and are being met in such an admirable fashion almost entirely by local funding in this facility, you can doubtless see the im-

portance of your support for the continuation of community efforts such as ours throughout Iowa. In addition, such support must include some provisions to insulate smaller hospitals (with necessarily limited budgets) from bureaucratic harassment of the type indicated in the clipping I have enclosed from our "DeWitt Observer." Our community has not asked for much help, but above all, the federal programs must not be a hindrance to our struggles!

"Innovative Programs in Primary Care" is a term being thrown about freely today and has a ring that captures the ear of the public; sometimes these programs appear innovative only because their progenitors do not know what has gone before. We citizens in your rural Iowa communities have, for the past twenty-seven years to my personal knowledge, already tried most of these "innovations" in one form or another. We have been advising patients to be more self sufficient, (simple medical care should be given at home—running to even a lesser trained person such as a nurse practitioner with minor problems, especially if it is "free" results in an enormous overutilization of any health care delivery system), we have provided good primary care in our individual offices and have cooperated to give medical-group-type coverage for emergencies 168 hours per week; we have maintained excellent referral lines with appropriate consultants in all of the medical specialties so that if the level of care required for the patient's illness exceeds the capabilities of our hospital, our attending staff, and our visiting staff, a well trained, immediately available ambulance corps is here to effect transfer under the most favorable conditions to the tertiary care level hospital.

Also, through the years, we have organized cooperative efforts in various aspects of delivering health information and expediting procurement of needed medical care, particularly for the aged and chronically ill. (I participated in a resumé by the County Medical Society about 1973, which delineates all these available—and largely volunteer, nontax supported—efforts in Clinton County; this report can be furnished if you desire.) These programs are still operative today, and appear likely to continue or expand.

Now, in addition, through the excellent cooperation and foresight of the gentleman who escorted you on your tour of our office, we have become affiliated with the Davenport Mercy-St. Luke's Family Practice Residency Program providing the DeWitt area with the service of one more well trained primary physician. The stimulus of a residency affiliation, the introduction of another young doctor to the opportunity and challenges of rural practice so that, hopefully, he will live and work, if not here, in another rural Iowa setting. Our Family Medical Center is operated in accordance with Dr. Smith's concepts for a complete self-contained primary medical care facility and will be expanded to provide the other ancillary services I believe he has discussed with you, whenever patient utilization rates justify those additional personnel.

(Those of us on the DeWitt Hospital staff—past and present—who have incidentally been bringing high quality medical care to your constituents throughout the years at very attractive prices, have all used the physician assistant concept to the full, through training at the local level, and know first hand the pitfalls as well as the advantages; so that any resistance we may appear to have to "innovative concepts" is rather that we can still remember that "Satellite Clinics" could all too easily become an instrument of mass referral and over utilization as well.)

In closing, I again thank you for your visit and for your interest in our local problems, problems which we have been facing on our own to the best of our ability. We have here and now perhaps a unique opportunity for participating more fully than most towns in preparing young doctors for rural practice, and wish to continue to do so, while at the same time furnishing medical care of high caliber to our corner of rural Iowa.

As doctors, we plan to continue to explore ways in which we can more efficiently and economically deliver that medical care; as citizens, we invite your help in providing health care; i.e. education concerning the approach of an informed individual to simple medical problems; action against the outstanding health hazards of diet, smoking, environmental contamination, poor personal habits, alcohol and war; and, encouragement of largely-volunteer and not tax supported preventive projects such as blood pressure check points and diabetic classes, to name only a few, to involve people in their own care.

We also ask that you heed the lesson of Canadian Medicare, which neatly decided last winter to solve its fiscal problems by closing all hospitals of fifty beds

or less—your rural constituents deserve better, and we feel that your rural hospitals have earned your support.

Sincerely,

G. W. MARME, M.D.

TOWARD BETTER HEALTH CARE FOR RURAL AMERICANS

(Karen Davis and Ray Marshall)¹

Few problems are more important to rural people than adequate health care. Despite the myth that rural people universally enjoy good health, solid evidence to the contrary exists. Infant mortality rates are as high as 70 percent above the national average in selected rural areas. Age-adjusted death rates are higher in nonmetropolitan areas than metropolitan areas, and have been declining at a slower rate in rural areas than in urban areas.

Chronic conditions afflict rural people more frequently and more severely than urban residents. Respiratory illness among adults and accidents related to the hazardous occupations of mining and farming are particularly serious problems in many rural areas. Death rates from accidents are four times higher in rural areas than in urban areas.

Much progress has been made in the last ten years in extending adequate health care to many disadvantaged Americans. This progress, however, has largely bypassed rural residents. Urban residents receive more medical and dental care than rural residents, and this gap has not been narrowing. Immunization rates and preventive health services are markedly deficient in most rural areas.

Financing rural health services

There are many interrelated reasons for the failure of rural residents to share fairly in the benefits of modern medicine. One major obstacle to improved rural health care, however, is inadequate financing.

Purchasing power is a major barrier to the use of health care services in many rural areas. Poverty rates in metropolitan areas are 10 percent compared with 14 percent in nonmetropolitan areas, and 20 percent in the nonmetropolitan South. About 40 percent of the poor live in rural areas.

Private insurance coverage tends to be limited since many residents of rural areas are unemployed or work in agricultural, other nonmanufacturing industries, or small firms where good employer group plans are scarce. About half of the farm population in the South has no private hospital insurance coverage, and about a third of the nonfarm, nonmetropolitan population in the South similarly lack coverage.

Public financing programs have not compensated for the inadequacy of private protection. Instead federal financing health programs are strongly biased against rural areas.

Medicaid

Medicaid, for example, was designed to deal with urban poverty. Eligibility is restricted for the most part to the aged, disabled, and single-parent families. As shown in table 1, 70 percent of rural poor family members have both parents in the home, compared with 39 percent of poor family members in central cities. Thus, most of the rural poor fail to meet the eligibility criteria for welfare and Medicaid, and receive no medical assistance.

This problem is compounded by the fact that a majority of the rural poor live in the South where Medicaid programs are particularly inadequate. Annual Medicaid payments in fiscal year 1974 per eligible AFDC (Aid to Families with Dependent Children) family averaged \$210 in Mississippi and \$1,570 in New York, compared with a national average of \$870.

¹ Testimony prepared for the U.S. Senate Subcommittee on Rural Development, Hearings on Rural Health Care, October 1976. Karen Davis is a Senior Fellow at the Brookings Institution in Washington, D.C., and Chair, Health Policy Advisory Committee of the National Rural Center, 1200 18th St., Suite 610, Washington, D.C. 20036. Ray Marshall is President of the National Rural Center and Director of the Center for the Study of Human Resources of the University of Texas, Austin. The views expressed here are those of the authors and not necessarily those of the officers, trustees, or other staff of the Brookings Institution and the National Rural Center.

TABLE 1.—DISTRIBUTION OF POOR FAMILY MEMBERS, BY TYPE OF FAMILY AND RESIDENCE, 1974

	Percent of total poor family members		
	Total	Two-parent families	Single parent families
United States.....	100.0	56.0	44.0
Metropolitan.....	100.0	46.0	54.0
Central cities.....	100.0	38.7	61.3
Outside central cities.....	100.0	57.1	42.9
Nonmetropolitan.....	100.0	70.3	29.7

Source: U.S. Bureau of the Census, Current Population Reports, "Characteristics of the Population Below the Poverty Level, 1974," p-60, No. 102, January 1976.

The Medicaid program does not collect and report systematic detailed data on the distribution of benefits by residence. It is urgent that better reporting be built into the Medicaid program to determine more precisely the nature and the seriousness of inequities in Medicaid. Some indication of these inequities, however, is revealed by a household interview survey in 1970. As shown in Chart 1, this study found that Medicaid payments average \$5 annually per poor child in rural areas, compared with \$76 per poor child in central cities.

A combination of factors account for the low benefits to rural residents. Many rural poor simply do not qualify for Medicaid because they do not fit the narrow eligibility categories established for welfare. Urban residents may also take greater advantage of Medicaid because the poor in urban communities tend to be better organized and more informed about eligibility for assistance.

The lower benefits received by rural residents also reflect the types of services covered by Medicaid. In recent years, a number of primary health centers employing nurse practitioner and other primary health practitioners have been started with financial support from state governments, the Appalachian Regional Commission, private philanthropy and community fund drives. In all but 6 states, Medicaid will not reimburse clinics directly for services provided by nurse practitioners. Nurse practitioners and other primary health practitioners have proven to be one means of providing quality medical care in rural areas which cannot attract or support a physician. These health professionals working under the supervision of a physician in a more distant location are hampered by legal restrictions and the failure of third-party payers, including Medicaid, to develop adequate methods of reimbursement for their services. Without better financial assistance from Medicaid, many primary health centers, particularly in low-income rural communities will find it virtually impossible to become financially self-sufficient.

Transportation is also an important barrier to medical care in some isolated rural communities. Without special programs to either bring patients to medical services or medical service to patients, many rural residents, particularly low-income persons, are unable to receive care even if that care is provided at low or no cost.

Since the poor in rural areas are inadequately represented by organizations supporting their interests, they are more likely to have ancillary problems which contribute to poor health including insufficient income maintenance, poor housing, inadequate diets, impure water, and inadequate sanitation. These conditions intensify the medical care needs of the rural poor, while at the same time limiting the effectiveness of medical care treatment. Coordination of medical care services with other supporting services, therefore, is particularly crucial.

Through this complex interaction of factors, poor rural residents are not receiving assistance from Medicaid commensurate with their health needs. While the poor as a whole have markedly increased their use of physicians' services since the introduction of Medicaid, rural residents have not made any gains relative to urban areas in use of medical services.

If the benefits of Medicaid are to be more equitably distributed among all of the needy poor, supplementary measures will be required to overcome many of the nonfinancial barriers which block the entry of these disadvantaged groups into the medical care system.

Medicare

The Medicare program also has provisions which cause it to be biased against rural areas. First, physicians are reimbursed on a reasonable charge basis. Since rural physicians serve patients with lower incomes and less private health insurance, rural fees have traditionally been lower than urban fees. The cost of a visit to the doctor's office in a small town average \$8.89. But in the nation's biggest city, the cost of the same office visit averages nearly three times as much—\$25.16.

The cost of running a practice is now less in the big cities than in rural places. Average practice expenses are \$33,000 for doctors in metropolitan areas with more than one million people compared with \$37,000 in nonmetropolitan areas. These figures verify findings of the Bureau of Labor Statistics that the cost of living is about the same in small towns as in big cities.

Some costs of starting a rural practice exceed that of urban areas. A rural physician starting a practice must often build a facility rather than lease available space, provide for their own support and laboratory services. Some rural physicians even have to pay to bring in municipal utilities and pave roads or parking lots to the clinic. Thus, a rural practice must internalize certain costs that are external to an urban practice.

While wage rates for routine office personnel may be somewhat lower in rural areas, other costs are correspondingly higher. Rural health practices face extra charges for delivery of equipment, maintenance and repair of equipment, and must sometimes pay higher wage differentials to attract skilled ancillary health professionals from urban areas.

Lower reimbursement rates for rural physician services, therefore, can not be justified on the basis of lower costs. Nationally, Medicare fees for rural physicians average 60 percent of those of urban physicians. A study we conducted in the rural South found that urban family practice physicians frequently received \$10 to \$15 more for a routine office visit than their rural counterparts (see table 2). Even though coverage under Medicare may stimulate demand by the elderly for additional medical services, the method of reimbursing physicians is not one which will serve to attract additional physicians to these areas.

Medicare also does not reimburse rural health centers staffed by nurse practitioners and physician assistants, with part-time physician services from larger, more distant communities. In a 1972 memorandum interpreting the Medicare law, then Social Security Commissioner Robert Ball argued that primary health practitioner services would be covered if a physician were physically present at the clinic at the time services were rendered. Larger urban clinics can meet this requirement, but rural clinics in small towns can not attract or support a full-time physician to supervise the services provided by primary health practitioners. Off-site supervision by physicians in more distant communities, however, has proven to be adequate to maintain quality standards.

TABLE 2.—MEDICARE PHYSICIAN FEE REIMBURSEMENT RATES, HIGHEST AND LOWEST REGION, SOUTHERN STATES, 1975

	General practitioner office visit	General practitioner hospital visit
Alabama:		
Jefferson County.....	\$35	\$40
41 small rural counties.....	25	40
Arkansas:		
Pulaski and Sebastian Counties.....	25	35
Small rural counties.....	15	25
Florida:		
Dade County.....	35	50
Small rural counties.....	30	30
Georgia:		
Fulton and other counties.....	50	50
Small rural counties.....	35	35
Kentucky:		
Lexington and Louisville.....	35	35
Rural.....	25	37
Louisiana:		
Orleans parish.....	15	45
Rapides parish.....	12	25
Mississippi:		
Metropolitan.....	20	25
Rural.....	10	15
North Carolina:		
Larger cities.....	28	50
Other.....	30	35

TABLE 2.—MEDICARE PHYSICIAN FEE REIMBURSEMENT RATES, HIGHEST AND LOWEST REGION, SOUTHERN STATES, 1975—Continued

	General practitioner office visit	General practitioner hospital visit
Oklahoma:		
Oklahoma City.....	35	35
Rural.....	n.a.	n.a.
South Carolina:		
Metropolitan.....	25	25
Rural.....	16	25
Tennessee:		
Shelby County.....	35	40
West Tennessee.....	20	33
Texas:		
Orange County.....	45	25
Hidalgo County.....	20	25
Virginia:		
Richmond County.....	25	30
Rural.....	20	22

Source: U.S. Department of Health, Education, and Welfare, Social Security Administration, unpublished data, 1975.

TABLE 3.—AVERAGE MEDICARE REIMBURSEMENT FOR HOSPITAL AND MEDICAL INSURANCE BY METROPOLITAN-NONMETROPOLITAN RESIDENCE, 1972

	Metropolitan counties			Nonmetropolitan cities	Ratio, central city counties to nonmetropolitan counties
	Total	With central city	Without central city		
Annual hospital insurance reimbursement per person enrolled					
United States.....	\$281	\$313	\$293	\$224	1.40
Northeast.....	322	377	316	249	1.51
North Central.....	283	324	286	236	1.37
South.....	231	256	243	204	1.25
West.....	305	328	300	234	1.40
Annual supplementary medical insurance reimbursement per person enrolled					
United States.....	\$108	\$125	\$114	\$78	1.60
Northeast.....	125	136	126	84	1.62
North Central.....	88	101	94	73	1.38
South.....	96	115	100	75	1.53
West.....	137	150	140	96	1.56

Source: Calculated from U.S. Department of Health, Education, and Welfare, Social Security Administration, "Medicare, 1972, Section I: Reimbursement by State and County," DHEW Pub. No. (SSA) 75-11704, 1975, table 1.1.3.

Table 3 summarizes the distribution of Medicare reimbursements by metropolitan-nonmetropolitan residence and by region. Medicare hospital and post-hospital payments per enrollee range from \$204 in the nonmetropolitan South to \$377 in Northeastern metropolitan counties with a central city. Average payments under the Part B supplementary insurance plan are twice as high in metropolitan counties of the West as in nonmetropolitan counties of the North Central region. For all regions, hospital payments per enrollee are 40 percent higher in major metropolitan counties than in nonmetropolitan counties and physician and other medical payments are 60 percent higher.

The distribution of Medicare benefits by residence is disturbing for two reasons. First, the elderly in rural areas, particularly in the South, have a much higher incidence of chronic conditions than the elderly in other areas suggesting that they should be receiving a more than proportionate share of health care services.

There is some evidence that the rural aged have fallen even further behind the urban aged in use of physician services in the two years following introduction of Medicare. In 1964, elderly persons in metropolitan areas saw physicians an average of 6.7 visits per person compared with 6.5 physician visits for the aged in nonmetropolitan areas. In 1973-74, average physician visits for the aged in metropolitan areas had increased to 7.0 visits, while average physician visits for the nonmetropolitan aged had declined to 5.9 visits.

A second source of concern regarding the unequal distribution of Medicare payments arises from the method of financing the program. Since a portion of Medicare is financed by premiums paid by the elderly, an unequal distribution of payments may result in subsidies of urban residents by the aged in rural areas. In 1972, for example, the elderly in nonmetropolitan areas of West Virginia and Kentucky received average Medicare physician's reimbursements of \$56. The elderly in major metropolitan areas of New York and California received over \$160 per person in the same year. Since each elderly person was required to pay a \$67 annual premium for physician coverage in 1972, the elderly in some areas of the rural South were paying more than they were getting back as a group.

With a uniform assessment for all persons, persons in low medical cost areas with a limited availability of medical resources pay not only the expected cost of their medical services but also a portion of the expected cost of services for other elderly persons. Higher medical cost areas and areas with more medical resources also tend to be higher income areas. Therefore, the premium method of financing derives revenue neither on the basis of expected benefits nor on the basis of expected ability to pay, but instead transfers funds from elderly persons whose incomes tend to be lower to those whose income tend to be higher.

Other obstacles to improved health care in rural areas

While inadequate financing of rural health services is one major obstacle to improved rural health care, many other forces act to impede progress. These include: (1) Incentives in the medical system and training of health professionals which mitigate against rural areas; (2) characteristics of the nature of rural medical practice; (3) legal restrictions and opposition of the medical, nursing, and other health professions; (4) the interrelated nature between health problems and environmental conditions in rural areas; and (5) racial/ethnic barriers and discriminatory practices that are particularly serious in rural areas where few alternative sources of care are available. It is important that an attempt to improve rural health take a broad approach which would both eliminate financial barriers and overcome many of these other obstacles.

The recently enacted health manpower act should reorient the training of health professionals toward service in rural areas. Increased scholarship and insured loan provisions should induce many more health professional students to pursue rural careers.

Expansion of the National Health Service Corps is also helping to focus more attention on rural health problems. The Corps has been very flexible in supplying physicians and other health personnel to a variety of rural health projects. Many rural places which could never have afforded a physician have benefited greatly from Corps supports.

In our study of rural health in the South conducted for the Task Force on Southern Rural Development, we visited a number of model Corps projects. We were somewhat concerned by the high turnover of Corps health personnel. Nationally, only 15 percent of Corps health personnel currently stay on in private practice in the areas to which they are assigned. This turnover causes some friction and dissatisfaction in rural communities served by Corps personnel.

More attention should be given to creating permanent, stable rural health practices. While there are many features of rural areas which make it difficult to establish such practices, innovative approaches to rural health delivery tried on an experimental basis have been successful in overcoming many of these disadvantages. The principal obstacles to stable rural practice are:

(1) In rural areas, medical professionals are concerned about being isolated professionally if they establish rural medical practices. Few opportunities are available for the continued professional development of rural physicians. While some states are moving toward greater decentralization of medical education, few internship and residency positions are available in rural areas. Thus, rural physicians are not exposed to the latest in medical science.

(2) Because there are few health professionals in rural areas, those who do locate there tend to have very limited time for their families or for recreation. Rural physicians are normally obligated to be available 24 hours a day while their urban counterparts can tell patients to go to a hospital emergency room or find someone else. Overwork is therefore a major cause of discontent among rural physicians.

(3) The limited availability of physicians in rural areas means that those who are there must see a lot of patients. To handle this load, physicians cannot spend as much time with each patient as he or she would in a less hectic practice. Patients recognizing this pace of practice are likely to come only with urgent medical

problems. Preventive care is neglected. Few support services such as laboratories, physician specialists, mental health professionals, and social agencies are available in rural areas. Thus, rural physicians have fewer resources, and many essential aspects of complete rural health care may be inadequately addressed. Rural physicians often leave rural areas because they do not feel that they do as much for their patients as they could in other areas.

(4) Population densities make it difficult to establish rural medical practices, because a minimum population is required to support a physician. It would be difficult to establish traditional medical practices in relatively small places. However, it might be possible to establish rural health systems using primary health practitioners to extend medical care into small communities. The population of a small town might not justify a physician, but it might support a nurse practitioner supervised by a physician located in a larger town.

(5) Rural areas often have trouble attracting health professionals because those communities lack the cultural, entertainment, educational, and housing facilities many professionals are likely to require. Moreover, the dominant value systems of many small towns and rural areas are likely to be incompatible with those held by many medical professionals. Special efforts, therefore, are required to match health professionals with rural communities.

Some new trends may affect some of the historic disadvantages of rural communities. The growing preference for rural life reflected in the opinion polls appears to be spreading to health professionals. An increase in women pursuing professional careers may lead to more husband-wife teams interested in rural practice.

Promising models of primary care delivery in rural areas

While there are many genuine obstacles to rural health delivery, our study of rural health in the South identified a number of approaches which have been successful in overcoming these obstacles. While much still remains to be learned about the most effective approaches for different types of rural areas, there are three organizational models of health service delivery which strike us as promising: (1) Primary health centers staffed by full-time primary health practitioners rather than physicians; (2) new types of group health practices and team approaches; and (3) comprehensive health centers providing a wide range of health and health-related services.

Primary health centers work well in small rural places which cannot economically support a physician or which are not attractive to physicians as practice locations. Typically, primary health centers are nonprofit organizations formed by local community groups or by state or local governmental agencies. These centers are small-scale organizations, employing one or two primary health practitioners, a receptionist who may also double as a laboratory technician, and a part-time physician who supervises the full-time nurse practitioners or physician assistants under contract to the center. Supervisory physicians may also agree to see patients at the health center one or more days a week.

Experience with this delivery model suggests that primary health services can be provided at relatively low cost in many communities. Primary health centers employing two primary health practitioners and other support staff average budgets of \$60,000 annually, and see 20 to 25 patients daily. At fairly modest fees (\$10 to \$12 per patient visit), the primary health center can recover its costs. Another strong advantage of this approach is recruitment and retention of qualified health personnel. Primary health centers which employ local residents who have been trained in local nurse practitioner or physician assistant training programs have had particularly high success in attracting and retaining professional personnel. Thus, many communities which are not attractive to physicians as places to reside or practice can benefit from primary practitioner services.

Another approach to health care which appears to be working successfully in larger rural communities is development of group health practices. The Robert Wood Johnson Foundation is supporting a model rural practice demonstration program designed to attract highly motivated physicians to rural areas on a permanent basis. This program establishes nonprofit group health practices staffed by a professional manager, two or more primary care physicians, and non-physician health professionals to relieve physicians of some of the burdens of overwork and professional isolation typical in solo rural practices. This arrangement permits time off for continuing education, interaction with professional peers, and supporting services from laboratories and other types of professionals—all features which are proving attractive to physicians and other types of primary providers.

Another approach which appears to work well in rural areas where poverty is deeply engrained is the comprehensive health center program. Unfortunately,

most of these projects have been established in urban communities. Many rural communities with serious nutritional and environmental hazards such as impure water and inadequate sanitation could benefit from this approach.

All of these approaches try to change the current health care system, rather than working within the current mode of private practice or traditional hospital outpatient departments. They share in common a strong emphasis upon nonprofit organizational structures with community boards, use of primary physicians and primary health practitioners on a salaried basis, and the substitution of less specialized for more specialized personnel where possible without undermining quality standards.

Recommendations

The recently enacted health manpower legislation should greatly increase the number of health professionals practicing in rural areas. To channel this supply into a system of health care which is permanent, stable, and meshes with rural conditions, it is important that a number of supporting changes be made in the reimbursement of health services, legal restrictions on the use of primary health practitioners, and organizational approaches to delivering rural health services.

Changing the financing of primary health care is particularly crucial to the economic viability of many primary health initiatives. We recommend the following:

(1) Amendment of the Medicare and Medicaid programs to reimburse health center services. Eligible providers should include all nonprofit ambulatory health centers providing primary health services and staffed by primary care physicians and/or primary care practitioners employed on a reasonable salary basis. Reimbursement should be on a reasonable cost basis, not fee-for-service, with minimum productivity standards based on maturity and location of center. Primary care practitioners include nurse practitioners, physician assistants, MEDEX, nurse midwives, dental auxiliaries, and other practitioners providing patient care in accordance with state laws.

(2) Amendment of the Medicare program to set rural physician reimbursement levels at the same levels as urban physician rates.

(3) Amendment of the Medicare and Medicaid programs to set aside 2 percent of all revenues for the development of permanent stable models of primary care delivery designed to meet the unique needs of different types of rural communities. Only through the deliberate sponsorship of resource development can the inequities in the distribution of benefits under Medicare and Medicaid be corrected.

(4) Implementation of universal, comprehensive national health insurance designed to promote the delivery of primary health services in rural areas. If coverage is phased in, we recommend that initial phasing be targeted on covering the rural poor and lower-income working families currently excluded from Medicaid and private health insurance plans. Reimbursement methods should be designed specifically to promote cost control and to encourage the development of resources in underserved areas. A health resources development fund should receive a fixed percent of all national health insurance revenues to be targeted on those communities receiving a less than equitable share of benefits. This fund should also provide financial support for environmental health services, nutrition, health education, outreach, and other supportive health services in selected rural communities. National health insurance benefit packages should include primary health center services when provided in organized systems of care outlined in the first recommendation above.

Legal/support and technical assistance should be given to promote the effective use of primary health practitioners. State Nurse Practice Acts and Medical Practice Acts should be amended to permit nurse practitioners and physician assistants with appropriate training to treat patients and write prescriptions subject to requirements on physician backup and supervision, written protocols, continuous auditing of primary health practitioner performance and continuing education. Such primary health practitioners should be permitted to see patients without the physical presence of a physician, if the backup physicians is available by telephone for consultation and such physician participates in a continuous auditing of primary health practitioner performance.

A long-run trend in the prevailing medical system in the United States has been toward specialization, which causes the training of physicians to be biased against practice in underserved communities. We approve the emphasis in the recent health manpower act on primary care and practice in underserved areas. The support of Area Health Education Centers and family practice residences in underserved communities provide valuable opportunities for continuing educa-

tion of primary health providers and for exposure of students to opportunities for service. Further support for preceptorships and training away from educational institutions is recommended.

We recommend that greater support be given to student efforts such as summer student health programs which acquaint medical and other health professional students with rural practice. We also recommend greater support to the development of localized primary health practitioner training programs, so that rural people will have greater opportunities to be trained to serve their communities.

Discriminatory or insensitive practices are particularly onerous for rural minorities who have few alternative sources of health care. Our study in the rural South uncovered many discriminatory practices that still persist—segregated waiting rooms, insensitive treatment of minority patients, and differential standards of care. Affirmative action in health training programs appears weak. Few minority women have been trained in the nurse practitioner training programs. The National Health Service Corps has few minority health professionals in its program. Since attitudes toward accomplishments are an important element in mental health, role models should be provided to rural minorities to demonstrate what can be achieved.

While these findings are tentative and not systematic, the evidence available suggests that several additional steps should be taken to improve health care for rural minorities. These include:

(1) A systematic study should be conducted of the extent, severity, and form of discriminatory or exclusionary practices in the provision of health care in rural areas, in the training of health professionals for rural areas, and in the administration of federal, state, and local health care programs.

(2) Local medical societies should be fully involved in the planning of rural projects but should not be permitted to block federal or state rural health projects.

(3) The National Health Service Corps should conduct a vigorous affirmative action program in the provision of scholarships for medical training and in the placement of health professionals in rural areas in order to increase the supply of qualified Spanish-speaking and black health professionals.

(4) The Medicare program should enforce nondiscriminatory practices in the provision of hospital care, nursing home care, private physician care, and other covered services.

(5) Programs to increase the sensitivity of health professionals dealing with minority groups should be undertaken.

These recommendations evolved out of our study of rural health care in the South conducted for the Task Force on Southern Rural Development. We presented these recommendations to a Southern Rural Health conference in Nashville, Tennessee, on October 10-12, 1976. This conference was sponsored by the National Rural Center, the Southern Regional Council, and the University of North Carolina; Vanderbilt and Meharry Universities also joined with the conference sponsors. This conference was attended by 275 people including rural health experts, members of health agencies, educators, legislators, doctors, primary health practitioners, and concerned citizens. The recommendations which we have presented here were endorsed by conference participants as meaningful changes which must be implemented to guarantee quality health care for all Americans.

[The following statement was referred to on p. 26.]

STATEMENT OF DR. PAUL FROM, CENTRAL IOWA HEALTH SERVICES, INC.,
DES MOINES, IOWA

Southern Iowa, as we have learned this morning, is one of a number of medically depressed areas within the state. There appears to be very little hope of improving the situation of medical manpower in this area in the near future.

In late 1975, a number of physicians in Centerville asked Sister Mary Gervase, the administrator of Mercy Hospital in Des Moines, and Chairperson of the St. Joseph Mercy Hospital Board of Directors in Centerville for help.

These physicians stated the hospital facility in Centerville is not the kind that they wanted, and that they would not be able to utilize that particular facility properly. They really wished to develop a connection with a Medical Center and a group of specialists. It was their feeling that their patients were going all over the country for medical help, follow up was too difficult with a widespread referral area, and that rural Iowa did not have equitable care to people in larger cities and this was not fair to those people. Comprehensive medical care was not being de-

veloped by the present referral system. Sister Gervase asked in whom they might be interested, and Dr. M. Parks mentioned Dr. Paul From and suggested that Dr. From be the organizer for the entire group.

Various discussions followed beginning on December 31, 1975 and from these discussions it became apparent that for a more efficient delivery system for health care for the Centerville area itself a tele-communications system or some system utilizing modern technology would need to be developed. Certainly, this would help solve the Centerville problem, but not necessarily for all the entire problem of the State of Iowa, as concerns rural health problems. If a modern technological system were not developed, there would be too much delay in receiving a report, and this would be too costly to the patient because reports were not promptly received. In addition, a plan must be developed that would encompass total health care rather than handling of one referral problem only.

It became clear that this system would then provide a reduction in cost factor, would help in recruiting at a rural level because of an intimate association with urban specialists, would allow for rapid results of all referrals, would give equitable health care in the rural area at a cost effective level, and would allow on-going education of the physician and paramedical specialist.

For the past two years I have been interested in problems of alternate methods of health care delivery and many people had looked to me for leadership in attempting to develop alternate methods of health care delivery. The Board of Directors of the Centerville Hospital looked to their physicians and to me for leadership.

Mercy Hospital, with which I am most closely associated, in Des Moines, had several experiences with Mr. David Neugent and his staff at Blue Cross/Blue Shield in experimental programs, and because Mr. Neugent and his staff had been quite innovative in these programs, I looked to Mr. Neugent for consultative help in developing this project. I knew Blue Cross/Blue Shield in Iowa was one of the few Blue Cross/Blue Shield programs in the country that keep administrative costs at a minimum for the Medicare/Medicaid program, had a wealth of talents, was extremely innovative, and was highly regarded at our own community level for efforts to contain health care costs. Thus, it seemed natural for me to seek their help.

We developed a plan revolving about a joint venture. The name of the organization is the Central Iowa Medical-Surgical Associates. At this moment 27 physicians belong to this venture, and 4 more will be added so that at least 31 physicians will be members. This venture will handle both the office and hospital practice of medicine as we know it today. The actual system is now in operation but is using the old and antiquated methods of communication and record keeping that is relied upon by physicians in hospitals.

The Mitre Corporation was asked for help, and we have met with Mr. Art Bennett of Mitre Corporation. Northwestern Bell Telephone Company has offered its services to help with this project in any way possible.

The Governor of the State of Iowa has expressed interest in the project, especially the utilizing of Emergency Transportation System via National Guard helicopters for those in Centerville and the Lake Rathbun area. Projected population on weekends and during the summer for the Lake Rathbun area is 100,000. Also, the Governor is very interested in rural health care problems in Iowa.

Satellites have already been developed because of this venture. One is open in Moulton and one is being developed in Moravia, and another is contemplated for Seymour, Iowa. An LPN staffs the satellite in Moulton and doctors visit there two afternoons per week. Physician extenders will undoubtedly be utilized at the appropriate time, but with this particular system there can be close supervision via Tele-communications network of the physician extender which is not possible with other methods of present utilization of the physician extender.

Many other rural areas are now looking to us for help, and particularly the cities of Osceola, Corydon, Leon, Creston, Albia and many others.

I believe that if we can work out the mechanisms for such a system we could, with the method, help enhance the capability of quality care, and with additional volume, look for even more cost effectiveness and cost containment. Health care costs could decrease with this system as the types of hospitals must change in the future, satellites develop, and other innovative methods be developed to handle the problems. Cost effectiveness such as a tele-health or tele-communications network has been well documented by the Mitre Corporation.

I would envision a computerized medical record with computer kept at the site of origin and at this time, do contemplate that we would utilize Augmented

Narrow Band Telephone wires for black and white television, transmittal of x-rays, transmittal of electrocardiograms and electronic stethoscope sounds, transmittal of microscope slides and fiberoptic visualization, transmittal of pulmonary function data and blood gas data, to name but a few. In addition, this system would allow for direct visual communication between the family physician and the referring specialist at any time in the day or at night if the home is utilized, and would be an excellent system for on-going physician education and paramedical education within the venture itself.

I believe that with the development of such a system, within a period of three up to at the maximum five years, a tremendous change or improvement could be brought about in the problems of rural health care in Southern Iowa. I believe such a system would become a model for solving many problems in rural health care, and would certainly, in the long run, be a very cost effective method for reducing health care costs while maintaining and improving quality medical care.

[The following article was submitted by Dr. James D. Kimball, see p.17 for his oral testimony.]

[From the Des Moines Tribune, Sept. 30, 1976]

"CLINIC ON WHEELS" PROVIDES MEDICAL SERVICES TO AFTON

(By Richard Hatfield)

AFTON, IA.—The services of a doctor are available in Afton for the first time since 1968.

The doctor comes here twice a week from Des Moines, and he brings his office with him.

It's a "clinic on wheels" staffed and operated by the College of Osteopathic Medicine and Surgery.

The medical van also spends two days a week in nearby Lorimor.

Folks in the two Union County towns say they are "super happy" with the arrangement.

The clinic is a specially equipped motor home donated to the osteopathic college by the Winnebago Corp. of Forest City.

"DOCTOR DAYS"

"Doctor days" in Afton (Pop. 823) are Mondays and Thursdays. In Lorimor (Pop. 346), they are Tuesdays and Fridays. A standard office call in the clinic costs \$7.

Spokesmen for doctor-recruiting committees in Afton and Lorimor said they hope to land full-time resident doctors as a result of the clinic-on-wheels plan.

The osteopathic college received a \$256,837 federal grant to operate the clinic for three years. Dr. Philip Pletcher, vice-president for academic affairs at the osteopathic college, said the clinic-on-wheels project has three major purposes:

To make medical services available in doctor-short areas of the state.

To give senior osteopathic students experience in treating patients under the supervision of a doctor.

To provide an opportunity for the student to learn what a small-town practice would be like.

"The plan ultimately is to assign students from Iowa to the medical van—to give them an idea of what practicing in a rural community is all about," said Pletcher. "Hopefully, the students will decide to set up practice in that community when they graduate."

MUTUAL ADVANTAGE

Pletcher said the mobile clinic not only gives a student the chance to find out what a small town is like, but also provides an opportunity for people in the community to get to know the student.

"We just hope the chemistry is right so they can get together," he said.

The mobile clinic is open from 10 a.m. to 5 p.m. and has been averaging 10 to 20 patients a day, Pletcher said.

The van is staffed by Dr. John Clark, the clinic director, a nurse, Kay Bandstra, and two senior osteopathic students, Chris Olson of North Huntington, Pa., and Aaron Sroka of Phoenix, Ariz.

"Other students who will be assigned to the van are looking forward to it," said Pletcher. "They see it as a challenge—an alternative to practicing in a bright, shiny hospital with 165 nurses running all over the place."

And, Pletcher said, residents of Afton and Lorimor are "super happy" to have medical services available in their own communities.

Marilyn Eginore of Lorimor and Mike Kelly of Afton agree. Both are members of doctor-acquisition committees in their communities.

"VERY ENTHUSIASTIC"

Lorimor has been without a doctor for two years, and most residents of the community have been going to doctors in Winterset or Creston, Eginore said.

"As a whole, the people here are very enthusiastic about the medical van," she said. "We are just hoping that it will bring us a doctor full time."

The Lorimor Lions Club is providing a waiting room for clinic patients in a building that housed the former doctor's office. In Afton, the waiting room is in the Masonic Building.

"Students assigned to the medical van are really trying hard," said Kelly, an Afton banker. "People here are saying they are getting a physical exam like they never got before."

Since the last doctor left Afton in 1968, Kelly said, townspeople have been going "in all directions" for medical care—to Osceola, Mount Ayr, Creston or Des Moines.

Said Kelly: "We'd sure like to get one of those students to set up a practice here. Actually, we'd like to land both of them—there's enough business in Afton and Lorimor for two doctors. It would work one man to death."

[The following material was submitted by Dr. Fickel and referred to on p. 36.]

EXHIBIT 1



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EXHIBIT 2

RURAL HEALTH INITIATIVE

The Public Health Service (PHS) Rural Health Initiative (RHI) is an administrative effort combining existing health resources of the Department of HEW to improve the delivery of health care to underserved rural areas. Grants and technical assistance to local non-profit organizations and groups are used to support the development of rural health care delivery systems. The PHS RHI seeks to combine existing elements of rural health care into integrated units that demonstrate how local comprehensive rural health care systems can be formed that are not only self-sufficient, but also provide career opportunities to attract and retain physicians and other health professionals in rural communities. All rural health projects provide physicians' services—preventive, diagnostic, and therapeutic; emergency medical services including transportation; laboratory and X-ray services; and linkages for hospitalization.

The RHI is being instituted in areas that are characterized by low population density; high proportions of elderly, poor, or uneducated citizens; poor transportation; and low physician/patient ratios. Access to medical services is difficult in many of these areas and impossible in others. Fewer rural people have health care plans, and third-party reimbursement rates are lower for those who do have coverage. There are fewer personnel, fewer facilities and poor access to those facilities that do exist in rural areas.

HEALTH UNDERSERVED RURAL AREAS

The Health Underserved Rural Areas (HURA) Program is a project grant program for rural health research and demonstration administered by the Bureau of Community Health Services (BCHS) as a key component of the PHS RHI. The program is authorized under Section 1110 of the Social Security Act which is the research authority of the Social and Rehabilitation Service. It is funded by Title XIX (Medicaid) program funds. This research and demonstration program has two principle goals:

Goal A: To integrate primary care services into a complete system of health care delivery that is financially viable, professionally attractive, and able to become self-sustaining. Within that goal are several specific objectives including services integration with the Early and Periodic Screening, Diagnostic, and Treatment Program, Maternal and Child Health Program, and the cancer screening programs of the National Cancer Institute. The program is also concerned with physician recruitment and retention, use of nurse practitioners and physician assistants, and the application of technology.

Goal B: To develop mechanisms to provide better health care to the Medicaid eligible population. Within this goal are objectives such as integrating the Medicaid eligible population into a single health care delivery system for rural areas, to increase the numbers of providers accepting Medicaid patients, and directly involving State Medicaid Agencies in experimentation around issues of eligibility, scope of service and financing health services to Medicaid eligible populations.

PHS RURAL HEALTH COORDINATING COMMITTEE

A Public Health Service Rural Health Coordinating Committee, formed in July 1975, is providing the leadership for integrating and strengthening PHS program efforts in rural areas and will consider the development of new approaches, policies, and programs directed at health problems in rural America. The Committee, composed of representatives of the Health Agencies of the Public Health Service, one from the Medical Services Administration, Social and Rehabilitation Service, one from the Office of Rural Development, Office of the Assistant Secretary for Human Development, and one from the Rural Development Service, Department of Agriculture, have taken the lead in coordinating program efforts to develop rural health care delivery systems in county and multi-county areas having the greatest need for services. The Health Services Administration serves as the lead agency and provides staff support for the Committee.

STATEMENT OF CONNIE MEINECKE, PHN, DALLAS COUNTY PUBLIC HEALTH
NURSING SERVICE, ADEL, IOWA

If there had been time for everyone to speak at the hearing on Rural Health Care, before the Subcommittee on Rural Development of the Senate Committee on Agriculture and Forestry, I would have said:

As a public health nurse working in a rural area, I feel there are many health needs that are not being met. There is a definite shortage of physicians and I do not see any indication that this will improve in the near future. In fact, I feel it will probably continue to become ever more of an intense need in our area—for instance of the 14 practicing physicians in our county 8 are in the 60+ age and four only work part-time. Because of the shortage of physicians, present ones are very overworked the quality of care is suffering immensely.

There are many contributions that public health nurses can do to improve the status of the rural health residents, but first physicians need to be educated as to what nursing is and does outside the acute care facility (hospital). And physicians need to change their archaic and monopolizing attitudes towards the health care system. In addition it must be noted that not even all the counties in Iowa have the services of a public health nursing service.

If more funds were channeled into public health nursing agencies such things as well elderly screening clinics, well child screening clinics and an increase in home health aides could help greatly to improve rural residents health status. A lot of elderly and chronically ill can be maintained safely and adequately in their homes if public health nurses and home health aides are available. Growth of these agencies was even further stifled when county governments budgets were limited to a 9% increase.

I enjoyed attending your Rural Health Care hearing and hope you have success improving the health care system—it definitely is in need of assistance.

STATEMENT OF ANNE ZIMMERMAN, R.N., PRESIDENT, AMERICAN NURSES'
ASSOCIATION, KANSAS CITY, MO.

The American Nurses' Association is pleased to have this opportunity to present our views on rural health care to the Senate Rural Development Subcommittee. We believe that access to adequate health care is a right of every citizen regardless of personal circumstances.

Two of the major barriers to receiving health care services in rural areas are the distances involved and relative scarcity of health services. This often causes residents of these areas to delay in seeking preventative care and health maintenance services. Persons in rural communities often suffer critical time lapse in meeting acute and emergency needs.

Rural communities have an extreme shortage of supportive services, i.e., mental health, meals on wheels, homemaker home health aide services, etc.

The professional health care provider working in a rural area is serving a decreased population base and thus has decreased financial resources. The provider is working in an area that has few other professional supports and resources. The provider often carries a 24-hour day, seven days a week responsibility. This can lead to physical exhaustion and, at times, less effective care. In addition, providers working in areas with few other resources may compromise their own standards of care.

Three specific recommendations for increasing the availability and quality of health care services to residents of rural communities are:

1. The provider should be a family health care practitioner such as a family physician or a nurse practitioner. It is important that the practitioner have patient and health education skills and knowledge so that he or she can provide preventative as well as acute care. The practitioner also needs preparation in the areas of occupational health and safety (e.g., pesticides, infectious diseases, environmental stresses, etc.).

2. The practitioner should have collegial type relationships with primary care providers in neighboring cities. Through arrangements with these colleagues, relief time, continuing education opportunities and peer review activities can be carried out. This will assist the provider in maintaining high standards of practice.

3. Information Retrieval Centers, such as HIRC in the Mountain States area, will provide the isolated health care practitioner with immediate access for referrals and consultation opportunities.

Nurse practitioners who have been prepared in programs that meet the ANA *Guidelines for Short Term Continuing Education Programs Preparing Adult and*

Family Nurse Practitioners are prepared as primary care providers. (A copy of the guidelines and a scope of practice Statement are attached to this statement.)

Federal funding for nurse practitioners training programs is needed to continue the support of these programs. On-the-job training in physicians' offices does not provide the type of preparation needed for these nurses.

Some states, Idaho, Montana, and Utah for example, have provided funds for registered nurses to obtain additional preparation as nurse practitioners. These nurses have then returned to their rural communities to serve as primary care providers.

The nurse practitioner serving in primary care provides prevention and maintenance services. The nurse's approach is family centered and includes pre- and post-natal care pediatrics, as well as care of the adult.

County Data—1970 Census

Selected population characteristics:

1970 population	20, 147
18 years and over	(65. 3)
65 years and over	(15. 4)
In places of 2,500 or more inhabitants	(14. 9)
Born in different State	(8. 5)
Change, 1960-70	(- 5. 9)
With telephones available	(94. 3)
White population	(96. 6)
Black population	
Spanish heritage population	
American Indian population	(3. 0)
Other	

Health occupations:

Number of physicians, dentists and related practitioners	45
Number of non-Federal physicians in patient care	6
General practice	6
Medical specialty	0
Surgical specialty	0
Other specialty	0
Health workers (except practitioners)	60
Nurses	51

Hospitals:

Number	0
Total beds	0

Selected occupations:

Total civilian labor force	7, 346
Professional, technical and kindred workers	606
Elementary and secondary teachers	270
Managers and administrators (non-farm)	549

Income:

Average family income	\$8, 903
Median family income	\$8, 047
Median income for professional, technical, and kindred workers	\$8, 765
Families with poverty-level incomes	(10. 5)
Number of families receiving public assistance	152
Average family income from public assistance	\$1, 224

Selected establishments and expenditures:

Number of hotels and motels	
Number of motion picture establishments	
Other amusement establishments	45
Number of wholesale trade establishments	279
Number of retail trade establishments	
Annual retail sales	\$34, 829, 000
Annual expenditures of local government	\$5, 900, 000

Education:

Local government expenditures for education	(64. 2)
Number of persons completing 4 or more years of college	526
Percent high school graduates, male	(49. 1)
Percent high school graduates, female	(58. 2)
Number of high school students	1, 749
Number of elementary school students	3, 334

Note.—Figures in parentheses are in percent.

STATEMENT OF PHILLIP SORENSON, MECHANICSVILLE, IOWA

While I am not able to attend this meeting in person, I would like to express my feelings in regards to a Pharmacy in a rural area. For the people in a rural area such as ours I feel that it is a wonderful service for all ages perhaps more so for the elderly and those not able to get around.

The services one receives there are very much confined to the patients health needs, as their concern is for the patients well being and health.

While at the Medical Center often the Doctor consults with the Pharmacist as to what would be the best medicine to prescribe. The Pharmacist here takes the time to explain what the medication is for and what it will do for you.

And in conclusion in this type of Pharmacy the Pharmacist's concern is strictly confined to the patient and not to the sales of other unrelated articles as may be in the store. I might add that from the Pharmacist I have learned much about the different medications and how they work on the different ailments.

STATEMENT OF JANE ROBERTSON, EXECUTIVE DIRECTOR, ILLOWA HEALTH SYSTEMS AGENCY, DAVENPORT, IOWA

On behalf of the Illowa Health Systems Agency, we want to thank Senator Dick Clark for providing the opportunity to discuss the issues of health manpower and health services financing in rural areas.

The Health Service Area which Illowa serves consists of two Iowa counties—Muscatine and Scott—and three Illinois counties—Henry, Mercer, and Rock Island. Based on 1970 census information, the total population of the area is 417,113. Of this total 237,634 persons reside in the five major urban areas of Davenport, Bettendorf, Muscatine, Moline and Rock Island. Therefore, approximately 180,000 individuals (approximately 43 per cent of the population) live in rural or semi-rural areas. In contrast to this, the vast majority of physicians, regardless of specialty, live in Davenport-Rock Island and the City of Muscatine.

As can be seen on page one of the attached materials, the national average of physicians, regardless of specialty, to the population is 12.9 to 10,000. Illinois is very close to the national average at 12.1 to 10,000, but Iowa is substantially lower at 9.1 to 10,000. None of the counties of the Illowa Health Service Area has as high a ratio as the states or the nation as a whole. The lowest is Mercer County with a 1.2/10,000 ratio and the highest is Rock Island County with a 10.2/10,000 ratio. It can be seen that the rural counties have a substantially lower number of physicians per 10,000 population than the urban counties.

The issues of how to attract medical manpower to rural areas are very complex. As medicine has become more and more specialized—to the extent that even family practice is considered a specialty—physicians tend to cluster in urban areas, particularly those with medical schools and universities. In these settings they have access to the sophisticated machinery that dominates medical care today. Offering tuition and loan forgiveness incentives to medical students who agree to practice for a given number of years in rural areas is one means of lessening the problem. However, chances are good that after the commitment has been met, the physician will leave the area and the residents will once again be without adequate medical care.

A possibility worth considering from both a manpower and fiscal perspective is that of the increased use of physician extenders in rural areas. It is less costly in money and time to train physician assistants and nurse practitioners. In rural areas they could function very well in making preliminary diagnoses, treating routine illnesses and injuries, referring patients when necessary for more specialized care, and educating the population in preventive health measures and self-treatment methods as appropriate.

Preventive care is probably the weakest level of care in our health care system. Educating people about good health habits and steps to be taken to prevent illness are relatively simple and inexpensive procedures. However, they tend to be underfunded and understaffed even in those few areas where they exist at all. One means of meeting this need would be to place increased emphasis on school health education programs.

In most areas communications systems are more than adequate to keep the physician extender in touch with her/his medical supervisor. Obviously, the programs must be carefully set up to ensure proper supervision of personnel. In this area, Iowa City, Davenport and Muscatine all have the resources to support physician extenders in ambulatory care settings in rural areas. Iowa City, in fact, would have resources to support such activities over quite a large geographic area.

While it might be desirable for each rural community to have its own physician(s), the realities of recruiting physicians to rural areas and financing the initial setting up of an office for the physician(s) make it unlikely that this will occur. However, it is our opinion that the increased utilization of physician extenders is feasible from both a manpower and financial perspective. Therefore, it is our recommendation that increased emphasis be placed on the development of ambulatory care programs in rural areas and that these programs be staffed wholly or in large part by physician assistants and nurse practitioners. It is also our recommendation that, as these programs are developed, emphasis be placed on building in a strong public education/preventive medicine component. These activities could be financed initially through an expansion of the National Health Service Corps program which has already provided some much-needed medical manpower to this area.

In addition, we urge that the Congress give consideration to increased funding for health systems agencies which are operating under the National Health Planning and Resources Development Act of 1974 (PL 93-641). These agencies have the responsibility of developing a more rational approach to the allocation of essential, but limited, health care resources. Without adequate levels of funding, their effectiveness will be substantially reduced.

We hope that these comments are helpful and will be pleased to assist you in any way possible concerning health issues in this area.

MEDICAL MANPOWER—MEDICAL DOCTORS

	Non-Federal physicians, total	Rate per 10,000 population ¹
National ²	266,587	12.9
Illinois.....	(13,539)	(12.1)
Henry.....	30	5.5
Mercer.....	2	1.2
Rock Island.....	171	10.2
Iowa.....	(2,609)	(9.1)
Muscatine.....	19	5.1
Scott.....	117	8.2
Illowa.....	339	8.1

¹ Population based on 1970 census data.

² Source: The Supply of Health Manpower: 1970 Profiles and Projections to 1990, DHEW Publication No. (HRA) 75-38.

MEDICAL MANPOWER—RATIO OF MEDICAL DOCTORS TO POPULATION¹ (PER 10,000) BY SPECIALTY

	National ²	Henry ³	Mercer	Rock Island	Muscatine	Scott	Illowa ³
Family practice	2.8		1.2	2.0	3.0	1.3	
Internal medicine	2.1			.9	.3	.6	
General surgery	1.5			1.1	.3	1.0	
Orthopedic surgery	.5			.5	.3	.4	
Vascular surgery	NA			.3		.1	
Plastic surgery	.08			.06		.07	
Neurosurgery	.1			.1		.07	
Dermatology	.2			.1		.3	
Urology	.3			.2	.3	.3	
Radiology	.5			.6	.5	.4	
Pathology	.5			.5		.3	
Proctology	NA					.07	
Allergy	NA					.07	
Anesthesiology	.5			.7		.5	
Psychiatry	1.0			.3		.8	
Ophthalmology	.5			.2		.4	
Ear, nose, and throat	NA			.2		.2	
Eye, ear, nose, and throat	NA			.06	.3	.1	
Obstetrics-gynecology	.9			.8		.8	
Pediatrics	.9			.4	.3	.6	
Emergency room	NA			.5			
Industrial	NA			.3			
Public health	NA			.2		.2	
Cardiology	NA			.06		.1	
Neurology	.2			.06			

¹ Population for all counties based on 1970 census data.

² Source: The Supply of Health Manpower 1970 Profiles and Projections to 1999 DHEW Publication No. (HRA) 75-38.

³ Distribution by specialty not currently available.

DISTRIBUTION OF MEDICAL DOCTORS BY AGE AND SPECIALTY, MARCH 1976

Specialty	Age				
	25-45	46-55	56-65	66+	Unknown
Mercer County: Family practice (2)	1		1		
Total	1		1		
Muscatine County:					
Family practice (11)	2	1	6	1	1
Internal medicine (1)	1				
General surgery (1)		1			
Orthopedic surgery (1)		1			
Urology (1)	1				
Radiology (2)	1			1	
Eye, ear, nose, throat (1)				1	
Pediatrics (1)	1				
Total (19)	6	2	7	3	1

DISTRIBUTION OF MEDICAL DOCTORS BY AGE AND SPECIALTY, ROCK ISLAND COUNTY, MARCH 1976

Specialty	Age								
	21-30	31-34	35-40	41-45	46-50	51-55	56-60	61-65	66+
Family practice (33)		1		1		3	4	7	17
Internal medicine (15)		1	2	3	3	1	4	1	
General surgery (18)		1	3	2	5	4	2	1	
Orthopedic surgery (8)		1	3		1	2		1	
Vascular surgery (5)			2	3					
Plastic surgery (1)				1					
Neurosurgery (2)		1					1		
Dermatology (2)							1		1
Urology (4)			1		1		1	1	
Radiology (10)			3	2	1	2	1		1
Pathology (8)			4	1		2		1	
Anesthesiology (12)		2	1	1	2	2	2	1	1
Psychiatry (5)			1	1	2	1			
Ophthalmology (4)				1		1	1	1	
Ear, nose and throat (3)				2	1				
Eye, ear, nose, throat (1)								1	
Obstetrics-gynecology (14)		1	1	3	1	2	2	2	2
Pediatrics (7)		1	2		2		1	1	
Emergency room (8)		2	3		2				1
Industrial (5)						2	1	2	
Public health (4)		1	2					1	
Cardiology (1)			1						
Neurology (1)			1						

DISTRIBUTION OF MEDICAL DOCTORS BY AGE AND SPECIALTY, SCOTT COUNTY, MARCH 1976

Specialty	Age								
	21-30	31-34	35-40	41-45	46-50	51-55	56-60	61-65	66+
Family practice (19)		1	4	2	2	1	4	1	4
Internal medicine (9)					1	2	2	1	3
General surgery (14)			1	2	2	4	1	2	2
Orthopedic surgery (5)			1	3					1
Vascular surgery (2)				2					
Plastic surgery (1)				1					
Neurosurgery (1)					1				
Dermatology (1)								1	
Urology (4)			1	1	1				
Radiology (5)			2		2	1			
Pathology (4)			2			1		1	
Proctology (1)									1
Allergy (1)								1	
Anesthesiology (7)			2	2			2		1
Psychiatry (11)		1	1	4		3			
Ophthalmology (5)			2	1	1		1		
Ear, nose and throat (3)			1	2					
Eye, ear, nose, throat (2)								1	1
Obstetrics-gynecology (11)			2		3	3	2		1
Pediatrics (8)			2			3	1		2
Cardiology (2)			2						
Neurology (1)					1				

MEDICAL MANPOWER, OSTEOPATHIC PHYSICIANS

	Total number non-Federal active osteopathic physicians ¹	Rate per 10,000 population
National	9,385	0.46
Illinois	233	.21
Iowa	288	1.0
Illowa	50	1.2

¹ Source: Osteopathic Physicians in the United States. A report on a 1971 survey. DHEW Publication No. (HRA) 75-60.

DISTRIBUTION OF OSTEOPATHIC PHYSICIANS BY AGE AND SPECIALTY, HENRY, MERCER, AND ROCK ISLAND COUNTIES, MARCH 1976

Specialty	Age			
	25-45	46-55	56-65	66+
Family practice (1).....				1
Manipulative therapy (2).....				2

¹ Henry County.² Rock Island County, 1; Henry County, 1.

DISTRIBUTION OF OSTEOPATHIC PHYSICIANS BY AGE AND SPECIALTY, SCOTT COUNTY, MARCH 1976

Specialty	Age			
	25-45	46-55	56-65	66+
Family practice (34) ¹	23	5	2	4
General surgery (2).....		1	1	
Internal medicine (4) ²	2		1	
Emergency room (2).....	1	1		
Radiology (2).....		2		
Endocrinology (1).....			1	
Anesthesiology (2).....		1	1	

¹ Includes 1 resident and 6 interns.² Includes 1 resident.

STATEMENT OF PHYLLIS R. BAKER, ELKADER, IOWA

I would like to make you aware of the potentials of physician's assistants, to counter balance the impression given by the MD's on the first panel, and to advocate the use of apprenticeship as a means of education. I shared the MD's concern and hesitation regarding a P.A. practicing in a satellite clinic or in doing the more subtle evaluations that a patient's problems may demand. When I graduated from P.A. school I would have been incapable of doing little more than physical exams, "protocol medicine", education, and hindsight medicine, i.e. the prescreened patient. However, after 3 years of working in the General Medicine Clinic at the V.A. Hospital, in Iowa City, with 2nd and 3rd year internal medicine residents, I have reached a degree of competency such that the comment was made by the Chief Resident in Internal Medicine at the University of Iowa (with whom I worked for a year, ½ day a week in our Rheumatology Clinic) that "we should just give an M.D. degree." We were discussing medical school at the time. I do not mean to imply that I know as much as an MD because, in truth, I know I have gaps in my skills of which this doctor was probably not aware.

However, I can, and intend to, fill in these gaps and continue my education to attempt to keep abreast of the new knowledge through self study and through an apprentice type situation and I wish to confirm for you the ideas which you seem to be aware of:

(1) potential for P.A.'s to learn and practice in full MD function (maybe a state or national "challenge test" for licensing)

(2) the value of the apprenticeship way of learning with its economic and social ramifications.

I have truly enjoyed hearing you today (and on TV) and want you to know I am very supportive of what you are doing.

NOTE: I would like to note 2 things: (1) I have quit my *city* job and am heading to work with an excellent general practitioner in rural Iowa (Elkader—pop. 2,000) who is thankfully, open to and wanting my learning as much as possible; (2) in the V.A. job, my daily practice involved doing the complete work up, outpatient, on new patients, the majority of which were referred by the local doctors or themselves after seeing their local MD.'s In the beginning, I consulted on every patient but the last year I consulted with the physician on less than 25% of the patients (except for therapy, scripts, approval) and of those 25%, well over 75% of the consultations resulted in confirmation of my initial impression or the directions my investigation was taking. The important thing is that it was a great opportunity for learning.

STATEMENT OF MILES WEINBERGER, M.D., ASSOCIATE PROFESSOR OF PEDIATRICS AND PHARMACOLOGY, DIRECTOR OF PEDIATRIC ALLERGY AND PULMONARY DIVISION, UNIVERSITY OF IOWA HOSPITALS AND CLINICS, IOWA CITY, IOWA

THE ROLE OF THE CLINICAL PHARMACIST IN RURAL HEALTH CARE DELIVERY

Because of the necessity of my presence at the American Academy of Pediatrics Meeting in Chicago, this message must be read in my absence. I did, however, wish to make a statement supporting the role of the clinical pharmacist. I have had personal experience working with clinical pharmacists in a multi-specialty group in California. Currently, I am utilizing the services of Dr. Leslie Hendeles who is on the Pharmacy faculty of the University of Iowa and is attending this meeting.

The consulting role of the clinical pharmacist to the physician, particularly to the generalist or the specialist outside of his own area, is often invaluable. Standard sources of drug information available to the physician such as the Physician's Desk Reference and other industry sources are not objective sources of information. Textbooks, on the other hand, are out of date. The clinical pharmacist with his general knowledge and communication channels for drug information can rapidly provide the physician with useful information related to drug selection. Equally important, pharmacists can also interact with the patient providing a drug education service that is likely to decrease physician time while probably increasing patient compliance. In a rural setting where patient volume is high and specialists are few, the added time on drug education can make the difference between success and failure in managing chronic diseases. Additionally, the clinical pharmacist can make protocol directed adjustments in medication dosage when authorized to do so by a physician. In these ways the clinical pharmacist can both increase the physician productivity while simultaneously increasing quality of medical care delivery.

STATEMENT OF RICHARD H. KUEHL, DAVENPORT, IOWA

My name is Richard Kuehl and I certainly appreciate the opportunity to present my views to this panel. As a rural resident and husband of a chronically ill person, I have a keen interest in rural health care.

Medical care in America appears to emphasize the profit system to the utmost. Doctors tend to practice where the money is and the money is where the people are. Sparsely populated rural areas and particularly economically depressed areas have great difficulty attracting physicians.

Presently there seems to be no system of providing medical care other than on a profit basis. The concentration of medical persons in large cities and medical centers is evidence that money assures the presence of persons trained to deliver medical care.

The state of Iowa has the highest incidence of Arthritis and other related rheumatic diseases per capita than any other state in the nation. Yet the state has only one practicing Rheumatologist and only limited rheumatology care available at the University of Iowa School of Medicine. Rural residents suffer a high incidence of arthritis because their average age is higher and many are or were employed in agriculture.

The National Arthritis Commission Report to Congress in 1976 makes some recommendations which would improve care of persons suffering from rheumatic diseases. I urge members of Congress to study this report and to insure the availability of funds so that the recommendations of the Commission can be implemented as soon as possible. There is great need for more research and better care for all arthritics.

It is the opinion of this observer that changes in state laws are required that would allow wider usage of paramedical personnel to conduct routine physical examinations, write prescriptions, dispense medication and treat minor ills and injuries. I don't believe the vast amount of education and training that is required to become a licensed physician is necessary to handle the majority of office calls routinely seen by the general practitioner.

First aid can be given by para-medical people in cases of more severe injuries and the patient can then be transported to areas of more extensive care. If possible illnesses are detected during routine physical examinations, para-medical people can refer the patient to a specialist. Medical centers should have helicopter

ambulances available for emergency use to transfer injured or acutely ill persons from remote rural areas. Wider use should be made of mobile diagnostic centers manned by medical technologists.

Many options are available to improve medical care to rural areas, but cooperation from the AMA is going to be necessary to implement them.

It has been argued that widespread use of para-medical persons would result in less than expert medical care, but it would be better than many are now receiving, which is none. Moreover, it would relieve the more highly trained physicians to concentrate on the more seriously ill and injured. Military corpsmen have been supplying emergency medical care in battle areas with great distinction. The experience gained in Viet Nam using para-medical corpsmen and helicopter ambulances could be applied to America's rural areas.

If the Federal Government can provide a 135 million dollar windfall for the drug companies in the swine flu program, with no concrete proof of its need, then surely we can expect some funds to improve rural medical care where proof of need exists.

[The following statement was referred to on p. 198.]

STATEMENT OF FORREST W. SMITH, M.D., DIRECTOR, MERCY-SAINT LUKE'S
FAMILY PRACTICE RESIDENCY, DAVENPORT, IOWA

Although the primary objective of the Mercy/St. Luke's Family Practice Residency is to train physicians in the medical discipline of Family Practice, an important and significant by-product of this educational process is the many service benefits derived by the Davenport community and the surrounding rural areas. An innovative approach was formulated using a unique blend of community health services, medical and allied health education, and research oriented to a rural primary care delivery system.

On July 1, 1976 the Mercy/St. Luke's Family Practice Residency Program opened a rural satellite clinic in DeWitt, Iowa. Currently this health care facility employs one full-time third-year resident physician and one part-time staff physician. Working from the DeWitt Family Medical Center, these physicians are providing comprehensive primary medical care to patients from DeWitt and the surrounding rural communities.

Although the resident is still in training, he has no hospital specialty services to cover while on the rural rotation. He can thus devote his entire day to examining patients. Also, because he is a licensed physician in his third and final year of graduate training, his skills in ambulatory care have been developed to the point that he is quite medically competent.

Although based in DeWitt, the programs would also be made available to the medically underserved areas of Malone, Low Moore, Welton, Charlotte, Lost Nation, Calamus, Wheatland, Lowden, Grand Mound, and Long Grove. The combined population of this rural area is approximately 20,000 people.

OBJECTIVES

The DeWitt Primary Care System has the following objectives:

1. Deliver regionalized and comprehensive primary medical care to patients from DeWitt and the surrounding rural communities;
2. Utilize, extensively, various allied health personnel to extend the availability, effectiveness, and efficiency of the physicians in this medically underserved area;
3. Maintain a program of a consistently high quality of care and cost-effective nature;
4. Promote the team approach to health care delivery through interaction with various community health resources and education programs; and
5. Serve as a demonstration model for the innovative delivery of ambulatory care in a rural setting.

OBJECTIVE I

Using the DeWitt Family Medical Center as a base of operation, various medical care delivery programs will be integrated into a primary care system serving this rural area. Because the programs will be conducted by one single organization, the patients will receive comprehensive primary health care. This means one agency will be responsible for the screening, diagnosis, treatment, and, if need be, referral of the respective patients.

Although the main emphasis of the proposal is on ambulatory care, the DeWitt Community Hospital is available for any elements of these programs that necessitate in-patient and/or more sophisticated medical services. The long-term care unit of the hospital will facilitate the delivery of the various programs to the aged and handicapped of the area unable to be moved.

Emphasis will be placed on the first contact medical care with responsibility for not only an individual patient but for his entire family. Because of the existing physician shortage in this rural area, traditionally the medical care administered was of an acute nature and limited to the therapy of a specific illness. In the proposed primary health care system, however, preventive medicine and health maintenance will be stressed.

Special emphasis will be placed on the following programs. These will be included in the services available through the DeWitt Family Medical Center.

1. Maternal and child care.
2. Cancer screening.
3. Pre-natal care.
4. Well-baby pediatric care.
5. Patient education.
6. Volunteer health service.
7. Venereal disease prevention and treatment.
8. Social counseling.
9. Emergency medicine.
10. Home health services (nursing, pharmacy, etc.).

It is estimated that the recently implemented Satellite Clinic will enroll and treat approximately 850 family units, or 2,550 patients, during its initial year of operation. By the end of its second year this figure should increase to 1,000.

OBJECTIVE II

Because of the primary care physician shortage in this rural area and the fact that many aspects of patient care can be performed by non-physicians, the proposed system will utilize extensively various allied health personnel to extend the availability, effectiveness, and efficiency of physicians. The project hopes to employ the following types of professionals:

1. Physician's Assistant.
2. Registered Nurse.
3. Social Worker.
4. Nutritional Consultant.
5. Patient Care Coordinator.

Patient health education programs are planned for the satellite practice. These will be patterned after similar programs currently being conducted in the Residency Program in Davenport. These educational sessions would be designed to foster the maintenance of health care and the appropriate utilization of the various health care resources.

Such programs would include classes in OB care, diabetic care, hypertension treatment, well-baby child care, and weight reduction. The staff-physician, resident, and all other allied health personnel will share responsibility for these patient education programs.

OBJECTIVE III

Quality care

All physicians affiliated in the DeWitt Family Medical Center are either Board Certified Family Practitioners or residents close to completion of their training in the same specialty. A benefit of combining a health care service program with medical education is the quality of care. A residency program combines the knowledge of recent medical school graduates with that of experienced practicing physicians. Because of the ongoing teaching, the most contemporary medical procedures, equipment, and philosophies are utilized. As in the parent office, the problem-oriented medical record is used in the DeWitt practice. Using this system, the patient's history, therapy, treatment, and progress is thoroughly documented upon each encounter. There is also considerable audit and peer review among the physicians. These many considerations promote a constantly high level of medical care.

Cost effective

Various means of enrolling and treating medically indigent people will be employed in the DeWitt primary care system. This will include a program to make the Medicaid eligible people of the area aware of the assistance for which they are eligible. The Residency Program will also negotiate with the Medicaid intermediary (Blue Cross/Blue Shield of Iowa) to secure coverage for home health and ambulatory services as an alternative to that of inpatient treatment.

OBJECTIVE IV

Community health resources

Although the community health resources are somewhat limited in the rural regions, the proposed primary care system will take advantage of existing relationships between the Family Practice Program and various health oriented agencies in the Quad Cities. Many of the programs will be developed with the Community Health Care, Inc. It is anticipated that all major social services of Davenport are represented at the CHC. Although oriented primarily to care for the indigent population of Davenport, the Community Health Care programs have been designed for the total health care needs of the community. The Mercy/St. Luke's Family Practice Residency Program is currently working in concert with the CHC on several projects. It is anticipated that this relationship will be expanded in the future as the Residency Program expands its medical service to Davenport and the outlying rural areas.

To promote medical and allied health education

The program was designed with community health services in mind. The DeWitt primary health care system will also have several beneficial provisions relative to the education of health professionals.

The residents will gain exposure to the idiosyncrasies of health care delivery in a rural setting. Studies have shown that 70% of the physicians elect to practice where they took their training. Hopefully the rural experience will motivate some of the residents to practice in a similar setting upon completion of their training. Because the resident and his family will live in DeWitt, they will become totally aware of the benefits a small rural community has to offer. From a professional standpoint, the resident will learn to practice medicine with somewhat less sophisticated facilities and equipment than perhaps he was accustomed to in medical school and previously in his residency.

The allied health education program will also benefit from the proposed system. By incorporating nursing assistants, physician's assistant, and other health care professionals through the DeWitt practice during their training may well provide the exposure necessary for recruitment to similar sized communities upon their graduation.

OBJECTIVE V

To serve as a demonstration model and for research

Our rural primary health center is lending itself to various research efforts. This system could become a model for the delivery of care in a physician-short rural area. The unique blend of service, education, and research delivered in a rural setting could well prove to be a partial solution to the physician shortage in rural areas.

Because of affiliations in Davenport, there will be two distinct population groups—urban and rural. These two population bases can be used for various studies contrasting the lifestyle of the urban and rural inhabitants. With our affiliation with the University of Iowa, expertise in research methodology could be easily obtained.

The Davenport Program is currently using a disease index. Developed in conjunction with the University, this lists all patients with specific diseases. By using a similar index in DeWitt, the contrasting environments can be used to trace their effect on disease patterns of the two populations. The Davenport Program has also been active in computer simulation, which could also be put to practice in DeWitt.

DEWITT COUNTY HOSPITAL

	Admissions		Patient days		Length of stay 1976	Occu- pancy, 1976	Outpatient		Lab		X-ray	
	1975	1976	1975	1976			1975	1976	1975	1976	1975	1976
January.....	72	82	667	518	6.56	55.7	338	463	1,592	1,802	219	219
February.....	62	69	509	577	9.0	66.3	329	441	1,103	1,656	218	260
March.....	63	82	568	652	8.36	70.1	321	526	1,170	2,050	215	259
April.....	78	62	428	551	7.45	61.2	397	573	1,492	1,702	193	227
May.....	68	78	402	484	6.54	52	348	460	1,238	1,489	201	198
June.....	75	59	507	525	9.37	58.33	392	587	1,293	1,920	206	296
July.....	73	85	469	509	5.59	54.73	381	637	1,433	2,251	179	335
August.....	61	99	410	492	5.29	52.9	424	601	1,212	2,203	222	333
September.....	68	70	423	483	7.21	53.66	486	546	1,107	2,089	201	280
Total.....	621	686	4,383	4,791	7.01	53.5	3,416	4,834	11,640	17,162	1,854	2,407
Difference.....	+65		+408		(1975)	58.28	+1,418		+5,522		+553	



