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By Mr. MAGNUSON (by request):

S. 4478. A bill to amend title 5, United States Code, to provide for maximum entrance and retention ages, training, and early retirement for air traffic controllers, and for other purposes; to the Committee on Commerce.

By Mr. HARRIS:

S. 4479. A bill for the relief of M. Sgt. George H. Jennings, Jr., to the Committee on the Judiciary.

By Mr. MONDALE:

S. 4480. A bill to improve the quality and availability of medical care in communities presently lacking in adequate medical care services; to the Committee on Labor and Public Welfare.

(The remarks of Mr. MONDALE when he introduced the bill appear below under the appropriate heading.)

By Mr. SPONG:

S. 4481. A bill granting and ceding to the city of Alexandria in the State of Virginia, certain waterfront land along the Virginia shoreline of the Potomac River, and for other purposes; to the Committee on the Judiciary.

(The remarks of Mr. SPONG when he introduced the bill appear below under the appropriate heading.)

By Mr. ELLENDER:

S. 4482. A bill to confirm the private land claim of William Kinchen; to the Committee on Interior and Insular Affairs.

By Mr. BAYH:

S. 4483. A bill for the relief of Luigi Fornasier, Lucille Maria Fornasier, and Lucio Fornasier; to the Committee on the Judiciary.

By Mr. STEVENS (for himself, Mr. BELLMON and Mr. HANSEN):

S. 4484. A bill to amend the Natural Gas Act of 1938; to the Committee on Commerce.

(The remarks of Mr. STEVENS when he introduced the bill appear below under the appropriate heading.)

By Mr. BYRD of West Virginia:

S. 4485. A bill to provide protection for heads of executive departments of the United States; to the Committee on Post Office and Civil Service.

(The remarks of Mr. BYRD of West Virginia when he introduced the bill appear below under the appropriate heading.)

By Mr. NELSON:

S. 4486. A bill to establish a national policy and program with respect to wild predatory mammals, and for other purposes; to the Committee on Commerce.

(The remarks of Mr. NELSON when he introduced the bill appear below in the RECORD under the appropriate heading.)

By Mr. HANSEN (for Mr. BENNETT):

S. 4487. A bill for the relief of William Arthur Herbertson; to the Committee on the Judiciary.

By Mr. GRIFFIN (for Mr. MURPHY):

S.J. Res. 243. Joint resolution authorizing the President to proclaim annually the day of November 1 as "National Women in Education Day."; and

S.J. Res. 244. Joint resolution to authorize the President to issue annually a proclamation designating the calendar week during which the third Wednesday of March occurs as "Community United Operation Total Health Week"; to the Committee on the Judiciary.

S. 4480—INTRODUCTION OF THE COMMUNITY MEDICINE ACT OF 1970

Mr. MONDALE. Mr. President, American medical care is the best in the world—for those who can find it and afford it. But soaring costs, the demise of the general practitioner, and the flight of doctors from small towns, rural areas, and the inner city are increasingly putting this care out of the reach of those who often need it most.

There are at least 53 counties in the Nation that do not have a physician; fully 37 percent of all U.S. counties have less than a third as many doctors, in relation to their population, as does the Nation in general. Even in areas where medical care is readily available—as we were recently reminded in testimony regarding the health of our migrant workers—certain segments of the population are scarcely served at all.

Our rural areas can be characterized by generally low-levels of available medical care. In the Nation's urban areas, however, service levels vary widely. Some areas have more physicians than can be used efficiently, while in others, the residents are tragically underserved. According to a recent survey of ghetto blacks and rural Appalachian whites, the prevailing health condition of poverty areas justifies referring to these groups as "the living sick." Pollster Louis Harris commented as follows:

> For two out of three people in the U.S., "feeling fine" means that there is nothing the matter with them. But for two out of three ghetto blacks and rural poverty whites in Appalachia, "feeling fine" means literally, "not as sick as usual."

In spite of unprecedented increases in personal expenditures for health, and notwithstanding an increase in the number of medical school graduates, there is no evidence that the Nation's poor are healthier, or find it easier to obtain medical care. The National Center for Health Statistics said 3 years ago that serious illness among the poor is appreciably higher than in any other group. The poor have four times as much mental and nervous trouble; six times as much arthritis and rheumatism; six times as many cases of high blood pressure; over three times as many orthopedic impairments; and almost eight times as many visual impairments. These findings would be no different today.

The typical response to this health care crisis has been to furnish assistance to those who cannot afford decent medical care—as in the medicaid program—and to assist medical schools in order to increase the Nation's supply of physicians. Over the past decade, for example, Federal appropriations for medical education have increased sixfold—from $95 million in the academic year 1958–59 to more than $600 million in 1967–68. Federal dollars now pay for 60 percent of all medical school expenditures, compared with 30 percent 10 years ago; and local, State, and private support has also risen. While greatly increased costs have eroded much of this increased support, the number of students and graduates have both increased somewhat.

However, it is becoming increasingly clear that additional physicians trained in the traditional fashion for our existing patterns of medical care cannot begin to achieve an equitable distribution of health care for all Americans. The maldistribution of physicians and the inefficient use of health personnnel are symptoms of fundamental defects in the way health services are organized, paid for, and governed. Where these structural defects have been corrected—as for example, in the Kaiser-Permanente and similar health plans—it has been found that unnecessary demand can be reduced, and that productivity can be increased without adding physicians. Clearly, it is time for basic reforms both in the Nation's health industry, and in the education and training which supports it.

Fortunately, promising reforms in the delivery of health care are already underway. A prime example is the proposed legislation to encourage the formation of large health maintenance organizations, which would pull together the personnel and facilities required to provide comprehensive health care. They would do so through annual contracts, at rates determined and paid in advance, thereby sharing the risk of illness with their subscribers. This key feature of the proposal would be a powerful incentive to provide quality services at the lowest possible cost. Methods for increasing productivity and reducing costs are already known and tested—automated laboratory equipment, computerized information systems, organizing health personnel into efficient health teams, and so on.

The introduction of these reforms will mean that future patterns of medical practice will bear little resemblance to what we know now. In order to prepare physicians and other health workers to function well under these changed conditions of practice, it is clear that parallel reforms should now be undertaken in medical education.

Dissimilarities between medical education and medical practice have long been the object of criticism. Distortions in medical training arise because of the academic isolation of the medical school from the health needs of the community. Clinical training occurs almost exclusively in teaching hospitals, which—in spite of their scientific and technological excellence—are far from typical of practice conditions the physician will encounter in the community.

Medical center patients are typically indigent, have rare medical conditions, and are often acutely ill. The emphasis in medical care is on expensive, episodic treatment, directed by a handful of eminent specialists. Moreover, the clinical training of physicians, nurses, and allied health personnel is planned and carried out independently, with no effective coordination of the activities of those who will be expected to function increasingly as a team, if forecasts of future medical practice are correct.

One medical school dean summarized the situation in these words:

> Service is on the basis of clinical experience. Involvement in a real life situation involving illness, worry, and death is a strong stimulus to learning. At the expense of exposure to these life situations, medical schools have tended to get carried away with the unusual and rare. They have preferred to expose the student more to such rare maladies as Henoch's purpura, syringomeylia, and ochronosis than to put him out where he can see those diseases he will most frequently see as a practitioner.

One unfortunate and ironic result of this is that, immediately surrounding many major medical teaching centers, there are pockets of poverty in which may be found the highest morbidity and mortality rates in the entire Nation.

In some medical schools, departments of community medicine have made valiant efforts to amend the health problems of the community, but there has been little support for their efforts. However, a growing number of medical educators is becoming aware of the problem and looking for solutions. The medical school dean I quoted a minute ago is now the Assistant Secretary of Health, Education, and Welfare for Health and Scientific Affairs—Dr. Roger O. Egeberg. In the same address from which the previous remarks were taken, Dr. Egeberg gave his views on the nature of the reforms that are needed in medical education if community health problems are to be alleviated, and if doctors are to be appropriately trained for medical practice. In the words of Dr. Egeberg:

Historically, medical education and medical service have been teammates since before Hippocrates. Recently, however, things seem to have fallen out of balance; service has regrettably become subordinate.

I would like to suggest that if we are to deal squarely with the increased and increasing responsibilities which confront the medical community, two issues are vital: First, we must restore the balance by assuring the exposure of the medical student to service during his own medical education within the framework of the medical schools. Second, and of equal importance, we must involve the medical schools more actively in service beyond its walls.

Mr. President, I am introducing legislation which addresses the critical relationship between medical education and our inadequate health delivery system. The basic objective of this bill, the Community Medicine Act of 1970, is to pull America's medical schools—their faculties and their students—out of their academic isolation and into the arena of true community health needs.

This bill will provide for special improvement grants to medical schools and teaching hospitals for the operation of medical care systems for underserved populations as an integral part of their clinical training programs. To be eligible for such grants, medical schools would be required to:

First. Revise their training programs to include clinical educational experience in communities which have clearly demonstrable, high health risks and low levels of service. This would be accomplished by reducing time spent in clinical training in traditional hospital settings, and by increasing time spent in comprehensive, family-centered clinical teaching centers that emphasize prevention, early detection, and home care.

Second. Plan these revisions jointly with hospitals, community colleges, and other institutions training nurses and allied health workers, so as to assure the inclusion of clinical training and experience for service on health teams during the undergraduate years.

Third. Establish comprehensive total health care service organizations for a defined, underserved population, although it would be understood that the population covered would not consist exclusively of persons from this underserved group.

Project grant funds will be used primarily for support of educational personnel and for research on the delivery of health services to the underserved. Grants will be awarded directly to medical schools and teaching hospitals, generally for a 4-year basic period, but extendable where appropriate for a period up to 3 additional years.

Proposed authorization levels envision grants to approximately 50 medical schools and teaching hospitals under the fiscal 1972 authorization of $25 million. Authorizations for ensuing years provide for a gradual growth in participation up to 300 medical schools and teaching hospitals under the fiscal 1976 authorization of $150 million.

Mr. President, four centuries ago the Chamberlain forceps was invented, a medical invention which was eventually to revolutionize childbirth. But for nearly 200 years this simple instrument of mercy was kept a family secret, and made available only to those who could pay enough. Women whose husbands were too poor to afford the forceps either suffered prolonged agonies of labor, or, as was common, died about as unpleasantly as one can. This state of affairs was accepted—unfortunate, perhaps, but good business.

Today we are faced with a similar situation. We have to decide whether American medicine is to remain a Chamberlain forceps—available only to those who can afford it—or is to be let out of our medical centers and made available to those who need it. If we are to say—as I believe we have been saying for a number of years—that decent health care is a birthright of all Americans, then we must be prepared to enact the fundamental changes to realize this vision. While this bill is only a step, I believe that it can become a vehicle for the basic reforms which must come in medical education.

I urge its favorable consideration by my colleagues, and I ask unanimous consent that the text of the bill be printed in the RECORD.

The PRESIDING OFFICER (Mr. HOLLINGS). This bill will be received and appropriately referred; and, without objection, the bill will be printed in the RECORD.

The bill (S. 4480) to improve the quality and availability of medical care in communities presently lacking in adequate medical care services, introduced by Mr. MONDALE, was received, read twice by its title, referred to the Committee on Labor and Public Welfare, and ordered to be printed in the RECORD, as follows:

S. 4480

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Community Medicine Act of 1970".

STATEMENT OF PURPOSE

SEC. 2. (a) It is the purpose of this Act to assist communities and defined population groups which are characterized by a lack of adequate medical care services to secure more adequate medical care services by making grants, as provided in this Act, to public and private nonprofit medical schools and community teaching hospitals which operate comprehensive medical care systems under which medical care services are provided to such communities or such population groups.

(b) Any grant made under this Act to any medical school or community teaching hospital shall be made for the purpose of assisting such school or hospital in establishing and operating, in connection with the comprehensive medical care system operated by it—

(1) programs which provide educational experiences for medical students, interns, residents, and other health care personnel;

(2) programs which have been jointly planned by such school and one or more hospitals, community and junior colleges, or other institutions, which provide training in nursing or the allied health professions under which students of such hospitals, colleges, and other institutions who are undergoing such training will obtain practical experience and specialized training while serving on health teams established and operated as a part of such comprehensive medical care system; and

(3) programs under which such school, hospital and other health care institutions or institutions providing training of nurses or allied health professions personnel will jointly undertake to provide comprehensive total health care services for a defined population group which is characterized by a lack of adequate medical care services.

GRANTS TO MEDICAL SCHOOLS AND TEACHING HOSPITALS

SEC. 3. (a) From the sums appropriated pursuant to section 4, the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary") is authorized to make grants, in accordance with the provisions of this Act, to carry out the purposes of section 2.

(b) No grant shall be made under this Act unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulations prescribe.

(c) (1) Grants under this Act shall be in such amounts and subject to such limitations and conditions as the Secretary may determine to be proper to carry out the purposes of this Act.

(2) In determining the amount of any grant to a medical school or hospital under this Act, the Secretary shall take into consideration—

(A) the number of medical students, interns, residents, and other health care students or trainees who would participate in the program with respect to which the grant is to be made;

(B) the number of individuals for whom improved health care services would be provided under such program;

(C) the extent to which the field of community medicine (when compared to other fields of medicine) is emphasized in the curriculum of such school or hospital; and

(D) the need of such school or hospital for assistance under this Act to carry out the program with respect to which the grant is requested.

(d) (1) Any grant under this Act to any medical school or teaching hospital with respect to any program shall be used only for the purpose of assisting such school or hospital to defray expenses incurred by it in meeting salary and other personnel costs for individuals participating in, supervising, or administering such program, or individuals engaged in research in the delivery of health services to defined population groups.

(2) Grants under this Act may be paid in advance or by way of reimbursement, and in such installments as the Secretary may determine.

(e) No grant under this Act shall be made to any medical school or teaching hospital with respect to any program for any year if, prior to such year, such school or hospital has received a grant under this Act with respect to such program for 7 years.

AUTHORIZATION OF APPROPRIATIONS

SEC. 4. For the purpose of making grants to carry out the purposes of this Act, there is authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1972, $50,000,000 for the fiscal year ending June 30, 1973, $80,000,000 for the fiscal year ending June 30, 1974, $110,000, for the fiscal year ending June 30, 1975, and $150,000,000 for the fiscal year ending June 30, 1976.

DEFINITION

SEC. 5. (a) For purposes of this Act, the term "nonprofit" when applied to any medical school or teaching hospital, means a school of medicine or hospital which is owned and operated by one or more nonprofit corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(b) For purposes of this Act, the term "teaching hospital" means any hospital which has graduate medical education program, approved by a natio. ally recognized accrediting body, and which makes extensive use, as defined by regulations, of the regular hospital staff in its medical education program.

S. 4481—INTRODUCTION OF BILL TO CEDE CERTAIN BOUNDARY PROPERTY TO THE CITY OF ALEXANDRIA

Mr. SPONG. Mr. President, at the request of city of Alexandria officials I am introducing a bill which would relinquish any title claim by the U.S. Government to certain boundary land between the city of Alexandria and the District of Columbia.

The Virginia shore property involved is located along the south shore of the Potomac River between Second and Gibon Streets, at Alexandria. The physical condition of this area has to such great extent deteriorated, stagnated, and become a source of pollution that it is, for the most part, a rundown wasteland.

Because of the uncertainty of whose responsibility it is to clean up the so-called mess, no one has accepted this responsibility. It is, therefore, extremely important, once and for all, to determine ownership, so that the duties and responsibilities may be assumed by owners of the riparian properties, with proper authority to maintain and keep the shore in a proper and good condition.

For many years, ownership of the property and the boundary lines in this area have plagued the United States, the State of Virginia, and the city of Alexandria. The details of the underlying facts which led to the present problem are contained in a report by a Boundary Commission created by an act of Congress, approved March 21, 1934—48 Stat. 453—a brief statement concerning which is contained in this memorandum.

To determine the boundary line between the District of Columbia and the State of Virginia, and in an effort to settle claims to property along or affected by said boundary line Congress, by the aforesaid act—jointly with an act of the Virginia General Assembly—created the District of Columbia-Virginia Boundary Commission.

The Commission was authorized and directed to survey and fix the boundary line and to have said line, when so determined, to be marked by suitable monuments. Following completion of its investigation, the Commission made its report, designated as "House Document No. 374—74th Congress, Second Session."

There was submitted to the Commission a proposed agreement between the city of Alexandria and the United States—pages 17–19—with respect to that portion of the Alexandria waterfront from the north line of the city limits to Jones Point. Among other things, the agreement referred to appropriate boundaries along the Virginia shore of the Potomac River, including the mean high-water mark on the existing natural bank or shore of the river, the line along and upon bulkheads by which the natural or filled-in area along said river or shore may be, which excepted any area where such bulkheads or other structures, if any, extended beyond the bulkhead line as may be established by the Secretary of War, in which event the boundary line, for that particular distance, shall be as recommended by the Commission to be the lawfully established bulkhead line. There was also reference for payment by the owner of Virginia upland of fair and reasonable compensation to the United States for any land which is filled-in below the high-water mark.

The Commission accepted the aforesaid proposed agreement between the city of Alexandria and the United States and recommended to Congress that it be adopted and confirmed.

The Commission's report further stated that the high-water mark of 1791 is a point of conjecture; that the U.S. Government has attempted to describe and locate this line; and that the same condition is true so far as the low-water mark of 1791 is concerned. The Commission concluded that its opinion was therefore that inasmuch as the line cannot be definitely established, the only equitable way in which a fair line can be arrived at, is by locating the low-water mark as of today, and recommended it as and for the boundary line existing and to exist between the District of Columbia and the Commonwealth of Virginia.

Subsequently, for jurisdictional and other purposes, and acting on the report of the Boundary Commission, there was established both a pierhead line and a bulkhead line along the shore of the river from Second Street to the District of Columbia-Maryland boundary line.

Under the act of Congress of October 31, 1945—59 Stat. 552, 554—the boundary was established between the District of Columbia and the State of Virginia along the aforesaid pierhead line. The act provided, however, that—

> Nothing in this Act shall be construed as relinquishing any right, title, or interest of the United States to the lands lying between the mean high-water mark as it existed January 24, 1791, and the boundary line as described in Section 1 (of the Act); or to limit the right of the United States to establish its title to any of said lands * * * or the jurisdiction of the courts of the United States for the District of Columbia to hear and determine suits to establish the title of the United States to all lands, in the bed, marshes, and lowlands, of the Potomac River, and other lands * * * below the mean high-water mark of January 24, 1791.

The area involved in the instant bill is that portion of shoreland between the bulkhead line and the 1791 mean high-water mark line. This portion of land is of no value to the United States and until the title defect is corrected, the city of Alexandria is unable to reasonably proceed with improvement of that portion of the waterfront, leaving it to remain as an unsightly, blighted area.

The PRESIDING OFFICER (Mr. HOLLINGS). The bill will be received and appropriately referred.

The bill (S. 4481) granting and ceding to the city of Alexandria in the State of Virginia, certain waterfront land along the Virginia shoreline of the Potomac River, and for other purposes, introduced by Mr. SPONG, was received, read twice by its title, and referred to the Committee on the Judiciary.

S. 4484—INTRODUCTION OF A BILL PROHIBITING THE IMPORTATION OF ALGERIAN NATURAL GAS

Mr. STEVENS. Mr. President, the United States is facing an increasing shortage of natural gas. Last fall during the debates on the depletion allowance, I warned that this situation was developing. I asked then that the Nation adopt a policy which would encourage rather than discourage the discovery of new reserves. Unfortunately, that advice was not heeded.

Now a new change in our policy threatens to discourage further our petroleum companies from investing in the development of a strong, stable industry. The Federal Government is, I am informed, considering the granting of permits to import natural gas from Algeria, a nation which has systematically confiscated the rights and property of American petroleum companies operating in that nation. In other words, in order to fill the shortage for which a shortsighted policy is partly responsible, we are, apparently ready to adopt an even more shortsighted policy and deal with pirates.

In August 1967, shortly after the Algerian Government had assumed control of the American oil companies on the pretext that we were a belligerent in the Arab-Israel conflict, that Government nationalized the refining and marketing properties of Standard Oil of New Jersey and Mobil Oil Corp. and has not yet compensated the companies involved for the properties taken.

During 1968 and 1969 the Algerian Government continued to attempt to extort more beneficial contract terms in return for the appropriated oil properties and has increased substantially the reference price on which royalties must be paid. In addition, Algeria has adopted a 100-percent repatriation requirement, which means that all money received for Algerian oil overseas must be returned to Algeria. In other words, American companies have received no payment for the property taken and are receiving no income from the properties "controlled" by the Algerian Government.

It seems obvious to me that it would be unwise for the United States to adopt a policy which would make it dependent on a country whose trading character is