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contractors before their work is completed. Surely, if we can afford such payments for defense construction, we can afford this desperately needed advance on payments to which farmers are already entitled.

But this is a matter of priorities. The administration has chosen a paper savings over the very real costs incurred by producers in the absence of advance payments. Last year, I wrote to the Secretary of Agriculture urging him to reconsider this decision. Yet, nothing has been done to solve the problem since that time.

I am hopeful that Congress will adopt our legislation and thereby help millions of farmers across America.

Mr. BURDICK. Mr. President, I join with my distinguished colleague from Minnesota (Mr. MONDALE) in introducing legislation that will make it mandatory for the Secretary of Agriculture to make advance payments to producers who participate in the wheat and feed grain programs.

We should not lose sight of the basic purpose of farm programs: To assure an ample supply of essential agricultural commodities at fair and reasonable prices while assuring producers of balanced production and orderly marketing so that the market will not be glutted and farm prices forced to such low levels that producers, unable to make a decent living, must abandon their farms. It is in the best interests of everyone that these programs operate effectively and fairly.

From 1961 through 1969, each producer participating in the feed grain program received shortly after the time of signup part of the total payment due for putting a stated percentage of his acres into conservation uses instead of grain crops, thus preventing a costly surplus grain buildup. This advance payment was made to encourage a large enough number of producers to sign up in this voluntary program to make the program serve its production adjustment purpose.

In December of 1969, the administration ruled that advance payments would not be made for the 1970 crops. Shortly after Secretary of Agriculture Hardin made this announcement, the Senator from Minnesota (Mr. MONDALE) and I introduced legislation to require the Secretary of Agriculture to make part payment to producers under both the feed grain and wheat programs in advance of determination of performance, The Senate Committee on Agriculture and Forestry held extensive hearings on the Agricultural Act of 1970 and the bill reported by the committee and passed by the Senate last year contained provision for preliminary payments to be made to both wheat and feed grain producers within 60 days after signup. These provisions, unfortunately, were lost in conference.

It must be remembered that farmers, more than any other group of businessmen in this country, need ready access to money or credit because their high, and steadily mounting, costs for seed, fertilizer, and related operating expenses recur annually. The advance payments in the feed grain and wheat programs can help ease their situation.

Without these payments, farmers must turn to other means of financing if they are not to transfer the burden of indebtedness to small town suppliers who, however willing they may be to help their customers, face exactly the same tight credit, high interest rate situation.

Bank credit is available to more financially secure producers, but it is both scarce and costly. The banks in our smaller communities are integral parts of the rural economy. When farmers prosper, they prosper; when farmers suffer from inflated costs of production and low prices in the marketplace, smalltown banks reflect their painful situation.

Young farmers who have not built a strong base upon which to fall back, and older farmers who have suffered adversity and yet hang on to their chosen calling through true grit and determination and the support and confidence of their families have in past years turned to the Farmers Home Administration for assistance through that agency's operating loan program. They are turning to the Farmers Home Administration this year, but with small success.

I would like to quote from a letter which I received from Dr. T. K. Cowden, Assistant Secretary of Agriculture, dated March 11, in response to a telegram I sent to the Secretary of Agriculture urging that the Department request a supplemental appropriation in order to provide adequate FHA operating loan funds for the balance of fiscal year 1971.

Dr. Cowden's letter reads, in part:

> The allocation of FHA initial operating loan funds for the 1971 fiscal year has been fully committed in most states. The Congress authorized $275 million for operating loans to be made from the Farmers Home Administration's direct loan account for the 1971 fiscal year. This is the same amount that was authorized for each of the three previous fiscal years.
>
> The demand for Farmers Home Administration operating loans has been very strong this year. The FHA is making every possible effort to meet the needs of as many of their applicants as possible with the funds available. . . . Due to the necessity to hold Federal outlays down, it has not been possible for the Farmers Home Administration to request additional funds for operating loans.

In view of this truly sad situation in regard to FHA operating loan funds, and the adamant refusal of the administration to ask Congress for additional money, the need for advance payments in the wheat and feed grain program becomes more urgent. If the Department of Agriculture will not, or cannot, make such payments without specific direction from Congress, then Congress should take action now to make such payments mandatory in order to make it possible for many struggling farm families to stay on their farms.

Such payments would represent no true additional outlay to the Federal Government. The expenditures will be committed in any case. It is simply a question of whether part shall be paid in this fiscal year or the entire cost be paid in the next fiscal year. It is a matter of choosing between a bookkeeping expediency and meeting a real need of our farmers.

It is my belief that almost all Members of Congress would vote in favor of the farmers if given the opportunity, and that is why I join in the sponsorship of this bill to make advance wheat and feed grain program payments mandatory.

By Mr. MONDALE:

S. 1301. A bill to improve the quality and availability of medical care in communities presently lacking in adequate medical care services. Referred to the Committee on Labor and Public Welfare.

THE COMMUNITY MEDICINE ACT OF 1971

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.

The unequal availability of medical care is reflected in our ranking among the world's most healthful nations. We rank eighth in life expectancy for females—behind the Scandinavian countries and England and France. We rank 13th in infant mortality—behind those same countries and Australia, New Zealand, and East Germany. We rank 27th in life expectancy for males—behind those countries and Japan, Poland, Czechoslovakia, Bulgaria, Greece, and the U.S.S.R. What is worse, while we are making progress, we are slipping back, relative to other nations. Twenty years ago, we ranked sixth, seventh, and 10th, respectively, in the same three measures.

There are at least 53 counties in the Nation that do not have a physician; fully 27 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 have repeatedly been 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 of 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 personnel 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 personnl 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, syringomyelia, 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 today introducing a bill which addresses the critical relationship between medical education and our inadequate health delivery system. This is the same legislation which I first introduced last October, as S. 4480. The basic objective of the bill, the Community Medicine Act of 1971, 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:

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.

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.

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 mean—as 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.

Mr. President, our present health delivery system is so badly in need of reform, it should not be made a partisan issue. The American people deserve nothing less than our most diligent effort to improve their health care. Advancement will not come easily, and if we are successful there will be credit enough for everyone.

It is in this spirit that I was glad to see included in the President's February 18 health message a number of proposals which follow very closely the concepts of this bill which I first introduced last year.

Under my bill, money is authorized for medical schools and community teaching hospitals to operate comprehensive medical care services in order to assist communities and defined population groups which are characterized by a lack of adequate medical care services. In his message, the President asked for "a series of new area health education centers to be established in places which are medically underserved". He went on to explain:

These centers would be satellites of existing medical and other health science schools.

The parallel is striking. Needless to say, I am very pleased to have the support of the administration on an issue which I consider to be an important part of any solution to the problems of our health care system.

This concept has received strong support from another important source, the Carnegie Commission for Higher Education. Shortly after I introduced my bill last year, the Carnegie Commission issued a comprehensive report which recommended action to "relate medical training more effectively to the delivery of health care." Toward that end the Commission proposed the same type of medical training and service program that was embodied in my bill. The President mentioned the Carnegie Commission report as the basis of his recommendations to the Congress.

Still another supporter of this approach is the chairman of the health subcommittee. Title II of S. 935, a bill introduced by the Senator from Massachusetts (Mr. KENNEDY) moves in the same direction as my bill. I am pleased to be a cosponsor of the bill.

I have been very impressed by the widespread positive response my community medicine bill has already received. Mr. Theodore Kummer, executive director of the Association for Hospital-Medical Education, wrote to the AHME membership asking for their views. Favorable comment has come from literally every part of the country—from the Northeast, the South, the Midwest, and the Far West.

I was interested to see in how many different places the concept I am recommending here has at least been started. An article in the Journal of the American Medical Association described the use of this approach at the University of Florida. Clearly a growing number of members of the medical profession are recognizing the potential of community health centers to provide for health needs heretofore unmet. However, as the letters indicate, unless we move to nurture these budding plants they may never come to full bloom. I sincerely hope Congress will give these public-spirited people the help they need.

Since we are all talking about doing the same thing, I hope we can move quickly to consider these various proposals and to shape the best possible legislation. I am proud to reintroduce my bill as the Community Medicine Act of 1971.

Mr. President, I ask unanimous consent that a number of the letters and the article to which I referred and the text of the bill be included in the RECORD.

There being no objection, the bill, letters, and article were ordered to be printed in the RECORD, as follows:

S. 1301

A bill to improve the quality and availability of medical care in communities presently lacking in adequate medical care services

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 1971".

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 through a health maintenance organization, health care services for a 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 limitation 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 seven 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, $110,000,000 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 a graduate medical education program, approved by a nationally recognized accrediting body, and which makes extensive use, as defined by regulations, of the regular hospital staff in its medical education program.

OVERLOOK HOSPITAL,
Summit, N.J., November 13, 1970.

Re Community Medicine Act, 1970–S4480.

Mr. THEODORE G. KUMMER,
Executive Director, Association for Hospital Medical Education, Arlington, Va.

DEAR TED: I wish to express my full support of the proposed legislation (S4480), which I feel will:

(1) be an effective means of delivering Health Care to the underserved target group;
(2) increase and more effectively utilize, existing resources both physical and human;
(3) provide a means for closer cooperation between the university and the community hospital;
(4) stimulate the development models for the delivery of comprehensive health care.

Sincerely yours,

WARREN B. NESTLER, M.D.,
Medical Coordinator.

WAKE COUNTY HOSPITAL SYSTEM, INC.,
Raleigh, N.C., November 17, 1970.

Mr. THEODORE G. KUMMER,
Executive Director, Association for Hospital Medical Education, Arlington, Va.

DEAR MR. KUMMER: I have taken the liberty of writing to Senator Mondale directly regarding his proposed legislation. It so happens that Senate Bill 4480 can be directly related to our attempts to affiliate with the University of North Carolina for the training of medical students on all services. At the present time we are negotiating an affiliation in Medicine, which is going to cost us an additional $100,000 a year, and it is not prudent to add this financial burden to the sick persons hospital bill. I am confident that it would be possible for us to develop affiliations on all services if Senator Mondale's bill became the law.

These affiliations serve the dual purpose of providing competent staff to fill the needs in the clinics in our hospitals, as well as providing a conducive environment for the University to use for student training. As you very well know, the University salaries for medical faculty appointments is more than the community hospital can afford; therefore, I urge the support of this bill before the Congress.

You may be assured that we will be willing to testify before the appropriate committee if that becomes necessary.

Yours truly,

WILLIAM F. ANDREWS, Sr.,
Administrator.

THE METHODIST HOSPITAL OF CENTRAL ILLINOIS,
Peoria, Ill., November 27, 1970.

T. G. KUMMER,
Executive Director, Association for Hospital Medical Education, Arlington, Va.

DEAR SIR: This is written in response to your memorandum of November 9, 1970. Subject: Community Medicine Act of 1970.

The Department of Family Medicine of The Methodist Hospital of Central Illinois, as a part of the developing program of the Peoria Medical School University of Illinois, and as a provider of community medicine is most interested in this bill.

One of the activities of this department has been the establishment of a Cooperative Family Health Center in cooperation with an existing Community Center of our black inner city area.

Although the existing Community Center and the people involved with it have most willingly provided facilities and some very limited manpower resources, and the Board of Trustees of our hospital has provided significant financial support; and, the physician members of our department and the others of the community have voluntarily offered of their time and services to staff the Center, it may well have failed for lack of funding. Certain essential parts of the Clinic's effort depends on financial support that is very difficult to achieve locally. This then represents a community effort on a voluntary basis in an area of very great need. Certainly this is a prototype that could be followed in many other cities of like and greater size. Under the provision of the bill, as we understand it, funding could be achieved that would allow this effort to reach its objective Not only would the goal of improved community health be realized but the Clinic as well as the other facilities of the family medicine program would and will be available to undergraduate and graduate students.

Although this is simply one instance in one area of a hospital's effort in community medicine and education that may well be duplicated in many other localities. We would, therefore, urge our support of this bill as well.

Although this information is very sketchy we hope that it will serve to illustrate the need for this type of funding from both an educational and health delivery standpoint, and hope that it will be received favorably. If we can offer any additional details or testimony in this regard we will be most happy to cooperate.

Sincerely yours,

FRED Z. WHITE, M.D.

GENERAL HOSPITAL,
Phoenix, Ariz., November 20, 1970.

Mr. THEODORE G. KUMMER,
Executive Director, Association for Hospital Medical Education, Arlington, Va.

DEAR MR. KUMMER: Thank you for sending your memorandum of November 9, 1970 re: Community Medicine Act of 1970—S. 4480.

Collectively, we at Maricopa County General Hospital are delighted to send the following comments to you:

1. We heartily endorse this proposed bill.
2. We would like to emphasize the need for availability i.e., not a part of university or medical school programs.
3. Cost of financing medical education (i.e., training of interns and residents, nurses, etc.) can no longer be totally subsidized by city, county, or state government or by hospitals or by patients alone. Federal support is mandatory:
4. Care should be taken not to eliminate teaching hospitals from grants just because they do not have family practice residency programs.
5. This should not be a program where government funds are allotted on a decreasing graduated scale, the difference to be made up by the teaching hospital budget.
6. Additional funds should be allotted for continuing medical education programs in teaching hospitals for practicing physicians, graduate nurses and paramedical personnel.

Thank you for the opportunity of sending you these thoughts. If I may be of further service to you, please permit me that privilege.

Sincerely,

THOS. L. HOLLIS,
Administrator.

TRI-COUNTY COUNCIL FOR CONTINUING EDUCATION,
Springfield, Ohio November 17, 1970.

Mr. THEODORE G. KUMMER,
Executive Director, Association for Hosptial Medical Education, Arlington, Va.

DEAR MR. KUMMER: Thank you for giving me an opportunity to comment on Senate Bill No. 4480 entitled "Community Medicine Act of 1970". I do, indeed, have some recommendations which I would like to call to your attention.

First, I would like to say that Senator Mondale's intent is very good. Since I work at the community level it is easy for me to say that the assumptions made about the acute need for better delivery of health care to rural and inner city populations is well founded.

Second, I want to bring to your attention the wording contained in the Statement of Purpose, Section 2, A. which says "To assist communities and defined population groups which are characterized by a lack of adequate medical services". When it becomes time to define specific population groups to be served by the provisions of this act it is my opinion that definite reference must be made to geographical location of these defined population groups in relation to the medical school or teaching hospital which would be designated to serve them. In other words, it is imperative for this proposed program to be available to communities far removed from university medical centers. In defining 'far removed' I am speaking of a distance of a radius of from sixty to ninety miles around the medical school or teaching hosptial concerned.

Yet another factor to definitely consider is the availability of our super highway system between the "purveyor" community and the "consumer community". In Ohio, the medical schools at Ohio State University and the University of Cincinnati have so many affiliated hospitals in their immediate environs that there is only token interest in affiliations with community hospitals located within an hour to one and one-half hours drive from the medical centers. Where such situations exist, change should be initiated. Taking a very permissive attitude toward these conditions will result in a retardation of progress reaching those people who need the most assistance, which is the goal of the Community Hospital Act.

Third, it is entirely possible that a small cadre of medical professionals will have to be placed in these communities that are removed from the medical schools.

Finally, I hope that you feel that my suggestions are of some value. If you decide that further amplification of my remarks would be of assistance to you and to Senator Mondale, please contact me. Again, thank you for approaching me. I am

Sincerely,

VAUGHN K. TAYLOR, *Ph. D.*

[From Journal of the American Medical Association, Oct. 19, 1970]

THE UNIVERSITY AND RURAL HEALTH: A YEAR IN MAYO, FLA.

(By Richard C. Reynolds, M.D.)

On Jan. 6, 1969, the Lafayette County Health Center began to provide ambulatory health services to the 3,000 residents of Lafayette County. This center was the result of mutual efforts by the faculty of the colleges of medicine and nursing of the University of Florida, members of the Lafayette County Health Department, and the citizens of the county. Seventeen patients were treated the first day.

This small rural health center is the first venture by the College of Medicine which attempts to provide comprehensive ambulatory health care to an unselected population group outside the hospital. Health services are not designated to a specific age, sex, disease, or economic group but are offered to all who live within the county. This rural health project does represent an increasing concern by the medical school in community medicine.

A RURAL LOCATION

Fifty-five million people in this country live in communities of 2,500 population or less. Despite a decline in the percent of rural residents the actual number of persons living in these sparsely populated areas has remained steady for two decades. However, only 12% of physicians, 3% of dentists, 18% of nurses, and 14% of pharmacists are located in these rural areas.[1] The problems of health care are further complicated by the distances between rural residents and hospital facilities, by the limited economic resources typical of many rural areas, and by primitive attitudes and beliefs that exist in respect to health and health services.[2]

Several metropolitan medical schools in the development of their community health care program have focused on the surrounding urban and ghetto problems. The College of

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Footnotes at end of article.

Medicine at the University of Florida is located in a predominantly rural setting. To begin teaching and training programs in the health care practices and problems of a rural location seemed reasonable.

SELECTION OF LAFAYETTE COUNTY

What better way for members of the medical school to study health services and needs of rural areas than to start, develop, and maintain a practice in a rural community. North central Florida is sparsely populated, and its residents compared to other portions of the state are poor.

Lafayette County is a prototype of many rural counties throughout the United States. It is 60 miles from Gainesville, the site of the University of Florida. The Suwannee River marks the northern and eastern boundary of the county. Cattle and poultry raising, dairy and tobacco farming, and harvesting pine timber are the major industries. The 3,000 residents of Lafayette County have been without the services of a local physician for ten years. Approximately 10% to 15% of the population is black. All black residents live in a sharply segregated area adjacent to the county seat, Mayo.

A visit to a physician by a person living in Mayo did require a round trip of 45 to 60 miles to Live Oak or Perry, Fla. Anthropological studies done over the four previous years revealed that many residents simply did not receive any medical care.[2] The few physicians in nearby counties are inundated by patients from their own localities. In one adjacent county, Dixie, with a population of 5,500, one osteopath alone tries to provide medical services. The shortage of dentists and other health personnel is equally great.

OBJECTIVES

The College of Medicine defined four specific objectives to result from its establishment of a rural health center. First, it was to provide and strive to improve ambulatory health services to the 3,000 residents of Lafayette County. Second, medical and nursing students by living and working in a rural community, by actually participating in the delivery of health services, would develop a concern for health needs of people outside of the hospital. It was hoped that they would begin to recognize and understand health and medical care as it is perceived by the patient as a member of his family and community. Third, the Lafayette County Health Center would focus study on the problems of health care of a rural community. These investigations would include clinical studies of minor and chronic ills among ambulatory patients, evaluation of the effectiveness and economy of health services, and examination of patient attitudes toward health. Finally, health care would be recognized as a cooperative experience with participation and interaction by all health professionals, patients, and community members.

COMMUNITY INTERACTION

The success of any health care project will always depend on the cooperation of the people being served. Cooperation often coincides with responsibility and participation. Before the actual selection of Lafayette County as the site of a rural health center, there were several meetings between the health professionals from the university and members of the community. The residents expressed their desire to participate in the project and thought the people in the county would patronize it. A Community Advisory Committee comprised of town leaders from the educational, business, and government worlds was activated before the clinic opened. This committee has served as a valuable adjunct to the health center and has contributed measurably to its success. A dialogue between the committee, representing the recipients of medical care, and the health professionals, the purveyors of medical care, was established. Hours of clinic operation, fees for services, housing for students, complaints from dissatisfied patients are freely discussed. The patients through their Community Advisory Committee representatives actually participate in planning their health care.

RESULTS

By the end of the first year approximately two thirds of the county residents had visited the Lafayette County Health Center at least once. There were nearly 6,000 patient visits. Medical students or the resident in medicine, who lives in Mayo and works with the students, made 500 house calls. More than 550 home visits were made by the nursing staff in response to follow-up clinic visits or at the specific request of a community member.

A full spectrum of illness is seen at the clinic. Most frequent are acute respiratory ills of the young. There have been minor epidemics of mumps, influenza, and conjunctivitis. The common chronic illnesses of the adult, arthritis, arteriosclerosis, hypertension, and diabetes, are treated. Usually six to eight persons each month are referred to hospitals from the clinic. The nearby community hospitals are used except in those few occasions when the greater resources of the teaching hospital seem indicated for the patient.

During the last three months of 1969 the Department of Ophthalmology of the College of Medicine has staffed an Eye Clinic one day each week. Twelve to 13 complete eye examinations are accomplished in this clinic. Since there are no ophthalmological services closer than 65 miles, this has been an invaluable addition to the health services now available to the people.

PUBLIC HEALTH

Public health practices have been incorporated into this community program and are not identified separately. A recent scare precipitated by a patient with diphtheria in a nearby county has caused us to review the immunization procedures of children. Despite the fact that immunization has always been available, free of charge, to children through the county health department, we estimate that only 60% of immunization are up to date. One goal during 1970 for the Lafayette County Health Center is 100% appropriate immunization of all schoolchildren.

In October 1969 the Florida State Division of Health appointed the Director of Lafayette County Health Center the acting County Health Officer. This appointment reflects the cooperativeness between separate organizational units involved in health care. It also demonstrates to the students the necessity or coordinating the management of acute episodic illness wth preventive medicine and health maintenance.

Future plans include the provision of more services to the residents of Lafayette County. We are working in concert with the newly forming College of Dentistry to bring dental services to this community. With the help of the Florida State Division of Mental Health we are trying to assess the mental health needs of this rural county. When needs have been defined, we will then establish a mental health program to meet these needs. There is precious little background data concerning mental health needs in rural areas.

EDUCATION

The colleges of medicine and nursing are primarily educational institutions for training of health personnel. Obviously we have examined this project carefully to see if it meets the educational goal of developing in our students a concern for health care of people in a community. We emphasize this goal because the health care we provide within the hospital meets only a few of a person's total health needs. The only way for the student to become aware of the patient's total needs in health care of health maintenance is to participate in health care delivery in the patient's community. This has been the most rewarding experience of this rural health center. During the first year, 60 fourth-year medical students rotated for three- to six-week periods in Lafayette County. They lived in the county and became, albeit briefly, community members. Similarly, 30 nursing students during their course in public health nursing spent four to ten weeks in Lafayette County.

All students have been encouraged to go beyond the usual boundaries of patient care as it is provided in the clinic facility. The students write an article for the local weekly newspaper describing health topics pertinent to the community. Subjects have included colds, "shots," immunizations, intestinal worms, tetanus, mumps, and influenza. Actually we believe that these articles may have influenced the patient's understanding of his illiness and his use of the clinic.

During a mumps epidemic, many children were brought to the clinic simply for confirmation of the diagnosis, reassurance, and advice concerning symptomatic treatment. Following a description of mumps that appeared in the weekly newspaper, the visits to the clinic for mumps abruptly declined. Subsequent patients with mumps orchitis suggested that the infection was still present in the community. During a mild influenza outbreak in the Spring of 1969, an article appeared in the *Mayo Free Press* depicting this illness as essentially self-limiting but with possible complications developing after three or four days. Again it was the impression of the students and physicians in the clinic that the brief newspaper article altered the patient's decision as to when to seek medical care. Apparently parents were now tolerating the first few days of their illness and seeking care only if the illness persisted or worsened after symptomatic treatment. Presently we are trying to devise an educational program on upper-respiratory tract disease, to see if specific health education can alter the decision regarding when a patient chooses to seek medical advice. A successful educational effort might keep patients from visiting the physician with benign self-limited disease but influence them to appear sooner with the complications of upper-respiratory tract disease for which the physician often has a specific and effective treatment.

Nursing students have developed a puppet show to illustrate dental hygiene which they present to the primary grades in the elementary schools. First-aid courses are organized for community members by the nurses, who have also attempted to form a club of diabetic patients for continuing education on the management of this chronic illness. Medical students have given several lectures to high school biology classes and are now considered a resource to the science teachers in the course. Health Center personnel have given numerous talks to local community groups such as Mayo Women's Clubs, churches, school classes, and Rotary Club. This community interaction by students is not traditional medical or nursing education. Its effect, however, is best summed up by the students themselves.

"As an experience in medical education, the clinic offers several unique opportunities. The patient population is unselected, with the physical and emotional, the benign and the morbid, and the sub-clinical and the end stage of disease thrown together. A knowledge of human behavoir and culture is essential in order to function efficiently in such a setting. Skill is required in the practice of meeting the needs of the patient as the patient sees them and in being able to withstand the anxiety, both yours and the patient's, of not being able to call the patient's difficulty by name or arrive at a diagnosis. In day-to-day practice of medicine

Footnotes at end of article.

this particular goal is achieved with clarity in only a small percentage of cases. It was fascinating to observe how the patient's concept of "good medical care" came to influence my approach to self-limited, generally benign processes." (Gary C. Hankins, MS4 (Class of 1969.)

". . . a unique educational experience which augmented and beautifully complemented the referral nature of Shands Teaching Hospital. In Mayo I was usually the first "physician" to see the patient. . . . Diagnosis at Mayo had to be made without the sophisticated "knee jerk" laboratory procedures we all use at Shands Teaching Hospital. Physical examination and improvisation suddenly became more important. We had to think twice before getting a simple chest x-ray. Cost of medical care to the patient came to the forefront. . . . I was left with certain concepts of health care and the role of the LMD. These concepts can be appreciated in such a short time only in a very small community as Mayo. I became acutely aware of the frustrations of a referring physician trying to utilize Shands Teaching Hospital. In a sense, for the first time I was on the outside looking in." (Walter H. Murshall, Jr., MS4 (Class of 1969).)

RESEARCH

In Lafayette County while delivering health care to residents we have tried to observe carefully the effect of our presence on the health of the community. These observations have provoked several studies. A sociologist is studying communication between the health professional and members of the black community. Following a clinic visit, the sociologist will interview the patient at home several days later to determine what the patient recalls from his visit and what instructions he is following. The sociologist then reviews the clinic records, sometimes discusses the medical situation with the physician, and tries to evaluate the success or failure of communication between the patient and his physician. The implications of this type of study are obvious. Faulty communication can vitiate any health gain that might result from the clinic visit.

A random 10% sample of the population has been identified in this county. Household members are interviewed weekly to determine the effect of illness on the daily functioning of any member of the household. One observation which we hope to make from this study is to discover if those who avail themselves of the medical services at Lafayette County Health Center actually have a decreased morbidity, measured by their ability to return to usual daily activity. This study will also try to define the extent of health impairment of this segment of rural population in a one-year period.

Even a cursory glance at rural health problems, the number of people to be served, the distances of people to health services, quickly reveals that the traditional providers of health care, the doctor and the public health nurse, have not been and will not be able to meet the demands for health services. To deliver health services to many rural areas paramedical people must be recruited and trained in providing primary care. The Lafayette County Health Center is an ideal location to study and define what the training of these ancillary personnel should be and to monitor their effectiveness in providing care.

A separate study has even attempted to refine the steps in medical decision making. One medical resident examined approximately 400 consecutive patients seen at the Lafayette County Health Center. He identified the complaints that brought the patients to the clinic, listed the examinations he performed to elucidate the complaint into a diagnosis, and recorded the treatment performed or recommended. Presently this information is being transferred to punch cards for tabulation and analysis. This type of data collection may provide some quantitative insight into medical decision making. It is from this study and others like it that we may begin to structure curriculum for the training of paramedical personnel to serve as primary-care physicians.

Developing health services for the residents of Lafayette County has yielded a community laboratory which has been helpful in more traditional clinical research. Surveys have revealed a pharyngeal carrier rate (17%) of meningocci in the throats of rural residents similar to that found in military recruits and denser populations. Routine immunization for measles, mumps, and rubella are given to some children by aersol insufflation to measure the acceptance and effectiveness of this method. One medical resident has described an illness which was part of the health folklore of the community. Workers cropping tobacco often become ill when performing this task after an early morning rain or heavy dew. The illness comprises nausea and vomiting, dizziness, and malaise and is self-limited in 12 to 24 hours. It appears to be related to a substance that is absorbed from the tobacco leaf through the skin of the worker. Historically it antedates the use of pesticides. It had already been dubbed "tobacco sickness" by the community.

COMMUNITY RELATIONSHIPS

Lafayette County is a poor community. Per capita income is less than $1,700. Lafayette County Health Center, however, is not an indigent-oriented clinic. Health services are available to all members of the community. At the insistence of the Community Advisory Committee a fee is charged for all services except for those to people who are known to be welfare recipients. Fees are adjusted when the cost of medical care appears to be unusually burdensome to any patient or family.

The Community Advisory Committee has remained a strong, vigorous unit. It was influential in persuading the county commissioners to underwrite some of the costs of serving those who are unable to pay. The county has recently purchased an x-ray unit to increase the services provided by the clinic. The close relationship between the Community Advisory Committee and the health professionals is extraordinarily important in making the health planning a mutual effort between the providers and receivers of medical care.

The clinic has had an interesting impact on the economic welfare of the community. Sales tax revenues for Lafayette County increased approximately 25% during 1969, compared to an average 10% increase in surrounding counties. Except for the clinic, there has been no other alteration in the economy of the county. Local merchants suggest that formerly visits to physicians in other counties were often converted into shopping tours. The increased sales tax receipts are a surprising finding, and we are trying to determine its relationship to the health center.

CONCLUSIONS

The initial objectives of the university in establishing the rural health center in Lafayette County has been met. Ambulatory medical services are available to the residents of this county. There are plans to extend the care to include dental services. Health education will bring to the community an awareness of the advantages of preventive medicine and health maintenance.

As an educational experience this health center appears to have had significant impast on many of the medical and nursing students. To enhance the student experience the College of Medicine has added a faculty member, a general practitioner, with a lengthy background in rural medicine. He will work closely with the students and house staff and will monitor the provision of health services. Whether this experience will influence a student's return to rural areas after graduation remains unknown.

The research implications of this rural health center have only been touched. There is now, in essence, a rural community in which imaginative and innovative health services may be critically reviewed. The Lafayette County Health Center is one year old. The university has only begun to learn how to study rural health problems. The existence of the health center, however, does represent the commitment of the university to explore further the health needs of rural populations.

FOOTNOTES

[1] Roemer MI: Health needs and services of the rural poor, in *Rural Poverty in the United States: A Report by the President's National Advisory Commission on Rural Poverty,* Washington, D.C., U.S. Government Printing Office, 1968, pp. 311–332.

[2] Murphree AH: A functional analysis of southern folk beliefs concerning birth. *Amer. J Obstet Gynec* 102:125–134, 1968.

By Mr. BELLMON:

S. 1302. A bill to amend title IV of the Agricultural Act of 1970 so as to extend the provisions of such title to the 1974 crop of winter wheat. Referred to the Committee on Agriculture and Forestry.

Mr. BELLMON. Mr. President, I am today, introducing a bill to prevent a repeat of a great injustice caused by delay in passing the new farm bill. My bill will not correct the mistakes of the past but it is intended to avoid a repetition of the unfair treatment which winter wheat growers have traditionally suffered when new farm legislation is under consideration.

Mr. President, for many months last fall, producers of winter wheat throughout the Midwest were kept in a state of uncertainty while the Congress delayed taking final action on the new farm bill. These farmers watched television, read newspapers, searched farm magazines, talked to county farm program administrators, wrote Senators and Congressmen, and did everything else in their power, trying to find out what the new rules would be.

In the Winter Wheat Belt, the crop year actually begins in June, and these farmers need information no later than July 1 as to the number of acres they will be permitted to plant and to how much land they will be forced to set aside. The farm bill was not finally passed and signed into law until late November. By that time, all the wheat in the Winter Wheat Belt had been planted.

Since there was no law on the books when planting time came, winter wheat farmers were forced to plant in the dark. Apparently, most decided to put out about the same acreage they had planted the previous year and hoped for the best. In many cases, they tilled and fertilized acres which they later decided to leave idle. Many decided to cut back on their plantings to be safe, while others, who were more optimistic, overplanted acres under terms of the new law and will now be forced to destroy their growing crops in order to be in compliance.

Since they did not have reliable information on which to base their tillage and fertilizer operations, winter wheat growers were placed at a great economic disadvantage. The results of this unfair and