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Statement
by
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U. S. Department of Health, Education, and Welfare
before the
Health Subcommittee
Senate Committee on Labor and Public Welfare
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Mr. Chairman and Members of the Committee:

It is a special pleasure for me to come before you today in order to support legislation to advance that part of the President's Health Message dealing with multipurpose regional medical centers. Our recommendations are embodied in the proposed Heart Disease, Cancer and Stroke Amendments of 1965, S. 596, introduced by the distinguished Chairman of this Committee.

I was privileged to serve for a time as a member of the President's Commission on Heart Disease, Cancer and Stroke, and am pleased that some of its recommendations were included in the President's Health Message. Secretary Celebrezze has indicated how the present bill proposes to carry part of these objectives forward. He has stressed the fact that improved care can be made available to larger numbers of people by the organization described as a medical complex. It should also be stressed that

this primary purpose of the bill--greater availability of better care--is best accomplished in environments and in institutions where research and teaching are also proceeding concurrently. The three faces of medicine--teaching, research and patient care--must coalesce into one image if the full potential of each is to be realized.

The proposed complexes represent a sound organization. In its report, the President's Commission noted that the proposed regional centers "would be established where possible in conjunction with a major existing medical institution" and that the proposal "represents an outgrowth and extension of an already successful program of the National Institutes of Health". The clinical research center program, now in its sixth year, has provided evidence that patient costs have not been oppressive, that the clinical research and training programs carried on in the centers have been well accepted by the physicians and institutions with which they are associated, and that a background of successful management procedures is now available. The proposal for establishing medical complexes therefore rests upon a foundation of experience and competence.

Since the proposed bill deals with three or more categorical diseases, each of which is of major interest to at least one of the National Institutes of Health, a word is necessary as to possible duplication and, conversely, as to coordination. The existing categorical programs carried out by the respective Institutes have flourished during the past two decades, and have thoroughly proved their great value in stimulating and supporting research on the dread diseases. Moreover, time has proved that all medicine has been nourished and strengthened as a spin-off from the effort made through the categorical approach. The scientists supported by a grant from the Heart Institute participate in the intellectual life of the university, and all science is the better for it. Biochemists, cytologists, or pharmacologists studying the cardiovascular system have made important contributions to their own and to other disciplines or specialties. Indeed, a drug which was one of the first tranquilizers, now so important for mental health programs, was discovered by a scientist searching for a drug having certain desired effects on blood vessels. The record now shows abundantly that funds to support categorical activities have helped greatly, not hindered, the broad advance of the health sciences.

A second point to be made concerns the relation of this program to the already existing Institutes. At the outset, one must emphasize again the primary purpose of the medical complex bill: to make available better care to more people. To reach this goal, research must be supported, and that is the primary goal of the categorical Institutes. Other programs, such as those in the Bureau of State Services, are concerned with the provision of health services. However, any possible duplication can easily be prevented through coordinative procedures prescribed in regulations, such as those which have long been used by the NIH and the National Science Foundation. In any event, support of activities whereby university medical centers, with their concentrations of highly specialized physicians and equipment, will more widely be available to patients in an entire region is new and does not overlap with existing programs. As in the case of the proposed organization itself, administration of this program rests again on a foundation of experience and competence.

Certain aspects of the program, especially those relating to the development of diagnostic and treatment stations in community hospitals, represent evolving relationships among the Federal Government, teaching and research

institutions, and the Nation's system of community hospitals. The evolution of this relationship should be closely watched and evaluated continuously as experience is gained. We regard the support of these stations, therefore, to be in the nature of a demonstration, to be carried out under regulations prescribed by the Surgeon General as provided in Section 906 and to be rigorously re-evaluated as required by Section 907 of the bill.

Since the urgent need for extension of care into the community will stimulate medical schools, research institutes and other local institutions to much greater than normal effort, it seems necessary to provide matching funds of up to 90 percent of the cost of required renovation and construction. As the program evolves, the ratio of matching funds for construction and renovation, as well as for operational costs, should be re-examined and re-evaluated in the light of experience.

Mr. Chairman, Secretary Celebrezze and I have thus far spoken in generalities rather than in specifics as to how a complex might be formed and how it might be used. As its very name denotes, a complex is a complicated

arrangement. It can appear in different guises to a patient, a practicing physician, a medical administrator, or a civic leader. I should like to describe how a complex might come into being and how it might function in some typical situations.

Let us assume that there is a city with a population of 600,000 near a State line and with about the same number in the surrounding suburbs. Within a radius of 100 miles there are three other cities of perhaps 100,000 population each. The entire population of the region is about 2.5 million people.

The central city has a university and a medical school, a university teaching hospital and several hospitals having 200 or more beds. Two of these (children's and VA hospitals) are affiliated with the medical school. Two of the other cities have one 450-bed hospital each, and the third has two 300-bed hospitals. There is also a State chronic disease hospital of 800 beds in the area and numerous small, 50 to 100 bed, community hospitals.

Planning the Medical Complex

The university, the medical school or the medical center in the core city assumes initiative in the planning and future development of the regional medical complex. The

first step is the organization of an advisory group representing knowledgeable and interested lay and professional citizens who live and work in the geographic area. Membership in this advisory group might include medical educators, hospital administrators, practicing physicians, research scientists, individuals involved in urban planning, individuals from health or welfare departments and other community leaders. This advisory group would assist a staff located at the university or medical school in the initial planning of the regional medical complex and in the preparation of an application for a grant to assist in planning this program. The initial application for planning funds would describe the existing institutions, agencies, and programs which would participate in the formation of the medical complex. It would also describe the relationships between these institutions necessary for the successful operation of the network, the geographic area and population base to be served, and other factors. After review of the application by the National Advisory Council on Medical Complexes, approval of the application would result in a grant that would assist the detailed planning, contractual negotiations, and other activities essential to the initiation of a

program of this scope.

Development of the Medical Complex

The medical complex would evolve gradually over a period of time as specific components are added. The ultimate goals in the particular illustration presented here involve development of a cancer clinical research center at the chronic disease hospital that has been developing an interest and expertness in the problems of cancer. A stroke clinical research center will be connected to the university teaching hospital where the neurologists, neurosurgeons and vascular surgeons have been carrying on active research programs and where is now located an active rehabilitation service much interested in the retraining of stroke victims. A heart disease clinical research center is planned for development in one of the nine general hospitals in the core city. One hospital, with 350 beds, has recently expressed an interest in affiliating with the medical school. It currently has a satisfactory teaching program with approved internships and residencies in several specialties. The department of medicine at this hospital has a full-time cardiologist who has been doing some independent research on a rather small scale in heart disease in addition to his other responsibilities in the

hospital. About 20 diagnostic and treatment stations in this regional medical complex would be placed in several of the voluntary hospitals located in the core city, the three or more mentioned in three medium-sized cities of 100,000 and a few in the hospitals in the geographic area with 100 beds. In a few of the largest hospitals there might be both a heart disease diagnostic and treatment station and a cancer diagnostic and treatment station. At the State chronic disease hospital, in addition to the cancer clinical research center, there would also be a cancer diagnostic and treatment station to which hospitals with less than 100 beds in communities not very distant could send their patients.

The main ingredient in the regional medical complexes is the willingness and desire of individual people, and the programs and agencies which they represent, to work together in an effort to improve the health services in the area and increase their accessibility by bringing to bear the energies and competencies of medical educators and biomedical research scientists in order to enhance the overall quality of patient care. Facilities and equipment are of course important. In this hypothetical regional medical complex it would be necessary to carry out renovation and to provide

equipment in order to develop the cancer clinical research center in the State chronic disease hospital. In the case of the heart disease center, the voluntary general hospital within the core city would have to undertake new construction on the hospital ground, but this would be related to its currently planned expansion program.

Young physicians who have recently completed their specialty training would be designated to head the stations located in the community hospitals. Each of these would be a member of the medical faculty, each would participate in the university's teaching and research, each would assist in the educational program provided by the hospital for its interns and residents, and each would arrange clinical conferences and other seminars through which the hospital's staff would learn new procedures and information known at the medical center but not yet applied at the local hospital. Such continuing education of the staff, and such participation in teaching and research assure that the system can constantly improve and renew itself.

Examples of Improved Medical Care

Benefits to patients deriving from access to any component of a medical complex can be dramatic. Consider the following hypothetical case.

A 47 year old school teacher suffered a heart attack. He was immediately admitted to Hospital-A in his community by his physician. His course was satisfactory until the third day in the hospital, when his heart stopped beating. Because of a training program in the management of cardiac arrest which had been conducted by personnel from the heart diagnostic and treatment station in Hospital-B in the same community, the staff in Hospital-A had been taught proper emergency procedures. In this situation an intern applied electrodes to the patient's chest and literally shocked him back to life. A second episode of severe irregularity in heart beat and its subsequent arrest occurred a few hours later. After a second recuscitation a cardiologist was called into consultation and subsequently the patient was referred to the heart disease clinical research center in another city. Therein, diagnostic studies led to the decision to implant wires connecting the patient's heart to an electronic, artificial pacemaker which would stimulate his heart beat. The subsequent management of this patient required the working together of the specialists and scientists in the heart disease research center, the specialists in the diagnostic and treatment station and the patient's own physician.

Lest it be thought that this hypothetical case is too artificial, I might say that one of the Nation's leading professors suffered just such a series of attacks a few years ago.

The regional medical complex also permits sharing the resources represented by facilities and equipment. Techniques for monitoring patients' heart beats through the use of miniature FM transmitters carried by patients and receiving and recording equipment located in a research center now exist and permit more accurate management of therapeutic procedures than was formerly possible. The medical complex offers the network for expanding this competence and resource to more physicians and to their patients.

Not only the patient, but the doctor as well, will benefit from the improved services available through the complex. Consider the case of a physician whose patient is hospitalized in order to carry out diagnostic studies concerned with a small growth on her thyroid gland. These studies led the physician to conclude that his patient had cancer of the thyroid. He referred her to a surgeon for consultation. The surgeon felt that, because of the patient's age, high blood pressure and rather severe lung disease, she would not tolerate surgery. Accordingly,

he suggested that the physician refer his patient to the cancer diagnostic and treatment station. At this station, by virtue of its connection with the cancer clinical research center, the physician was put in touch with a research physician trained in nuclear medicine and licensed by the Atomic Energy Commission to administer radioactive Iodine 131--an alternative to surgery in the treatment of certain patients with thyroid cancer. Without the availability of such a resource, many patients in the same situation either would be forced to travel great distances to large teaching centers or their physicians would have to rely on less adequate procedures.

Because of this experience, the physician learned of the resources available in the complex. Later, when another patient in his practice had a child with a congenitally deformed heart, he was able, through the cancer specialist who had initially helped him, to meet the cardiologist at the heart disease clinical research center. The experimental diagnostic and operative procedures being developed there permitted an operation which completely restored the child to health. The physician had been assisted to accomplish something otherwise impossible.

Examples such as these could be multiplied indefinitely. Each would indicate how the organization of the complex aided people. Patients would receive better care, physicians would receive improved assistance, both would benefit from the availability of equipment otherwise too new or too expensive for ready accessibility. The increased efficiency brought about by large-scale community planning and effective use of resources would benefit the population at large.

Mr. Chairman, I believe the proposed legislation will go far toward improving accessibility of high quality patient care. I earnestly recommend it for your favorable consideration.

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