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November 9, 1965

Mr. John Russell, President
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522 Fifth Avenue
New York 36, New York

Dear John:

I am writing you, as you requested in Baltimore on November 6, relative to the reasons behind my expressed feelings of the importance to the Schools of Medicine of Public Health Service Act Title IX ("Heart, Cancer and Stroke"). At the outset let me simply indicate that my personal feeling is that this Act, and its sequelae, will have an impact of major importance on medicine and medical education. I suspect the historians of the future will find its impact equal to, or greater than, the development of the clinical clerkship at Hopkins, the Flexner report, the evolution of the full-time faculty or the growth of federal support in medical research during the last two decades.

Why? Because this Act in one package immediately affects, at a rather basic level, all three aspects of our profession--patient care, education and research. It has been stated, whether correctly or not (I will not debate), that it grew out of a demand of our society for a better distribution of the quality and quantity of health care, out of a need for bringing the advances of the medical research scientist more rapidly to the ultimate goal--the recipients of health care. If it is to achieve this goal I am fairly confident it will perforce have a direct effect on our national medical research effort. I do not mean that it will necessarily impede the basic research growth that has occurred through the NIH, but I feel it will create a different (hopefully additive) emphasis. There will be greater and greater use of PHS funds for training grants, not for the training of researchers but for the training of young men in the clinical use of the information produced by the researcher. The bellwhether of change in emphasis is readily seen in the recent alteration of approach in the

Clinical Cancer Training Grants and in the very recent establishment of the Cerebrovascular Clinical Training Grants. Here I would underline the term Clinical Training. This change in emphasis is an obvious and necessary one in order to produce one type of manpower needed for the success of Heart, Cancer and Stroke. It will in a relatively short period of time significantly alter many of the post-graduate educational programs going on in Medical Centers. In that the pool out of which the participants in such programs will be drawn will be essentially the same one as our current research trainees, there may be even broader implications for the future than an alteration in post-graduate programs alone.

In addition I would anticipate a change in the kinds of research (again I hope an additive change) that will be supported. There will be more interface or applied research. There will be far more social research in the area of patient needs and patterns of distribution of medical care. This will bring medicine and the social sciences even closer together in common and related research goals with great benefit to both.

However, I feel that even more startling changes will occur as a result of the patient care implications of this legislation. Over the years the University Medical Centers have become moderately well isolated from the medical community at large. I need not dwell on the reasons for this (growth of full-time faculty, research emphasis, etc.), but the "town and gown syndrome" is a real rather than imagined disease. Much has been written about it and even national symposia have been held in an attempt to find a cure. I would like to submit that Title IX will be the most effective therapeutic modality yet conceived. Indeed as time progresses, Title IX and its sequelae may prove to be as specific for the "town and gown syndrome" as penicillin has been for the Beta hemolytic streptococcus.

It will force the University Medical Center out of its ivy-covered walls and out into the community at large. The Act specifies regional medical care programs and stresses throughout cooperation of all those involved in the provision of medical care. It requires that patients be referred by practicing physicians (a government-accepted AMA compromise that was undoubtedly acceptable in that it was one of the facets that insured cooperation). It goes further by

requiring that practicing physicians and local medical societies be involved in the regional advisory committees. A final check in cooperation occurs at the National Advisory Council level as well. It will indeed be interesting to observe the approach of those insular medical centers who have shunned and occasionally scorned the local physician, who have avoided the county medical society, and who have decried the AMA from without, as they attempt to repair the wounds created by their attitudes over the years. It will take considerable time and effort for in many communities the "town and gown syndrome" is not only acute, but quite chronic. For many of the State schools this aspect of the problem will not be very significant in that their relationships may already be fairly healthy. Having grown up in the "land grant" tradition with extension services having roots in the communities of the State, many have already established some quite acceptable patterns of relationship not only with the State medical community but the community at large. However, even in these instances there is not one situation that is not in need of improvement. In other less fortunate institutions it will take a total attitudinal about-face. I am convinced, however, that the pressures are now, or will be in the future, sufficiently great to bring about the 180 ° turn that will be required. And I can only shout "hurrah", for in the long run everyone will benefit.

The regional concept will bring the University Medical Centers within various regions into far more intimate contact with each other than has previously occurred. Many have been isolated not only from the practicing community, but from other medical schools in their region as well. Indeed, in some instances there has been direct competition among medical centers in a given region. It was interesting to see the kind of cooperation and new alignments that were becoming evident at the recent AAMC meeting which were stemming directly from the pressures of Title IX. Out of this will come a more realistic, and hopefully more efficient, approach to the provision of medical care in their regions.

Not only will physician-to-physician communications improve, but communications of physicians with the rest of the "medical care team" will occur. As we attempt to improve the quality and quantity of care, it will become even more

obvious than it is now that quality and quantity cannot go hand in hand without more efficient expansion of the medical and paramedical groups with close effective cooperation of all concerned.

The effect of Title IX on medical education (and here I am using the term in the "Coggeshall" sense) has the possibility of being truly revolutionary. The basing of the programs in "major medical centers" will intimately involve, either directly or indirectly, most of the medical schools in the country, and it will involve them throughout the entire spectrum of medical education. I have already referred earlier to some of the effects in the post-doctoral area and will not comment further about this group.

A truly significant effect will be felt in the area of continuing education. As you well know the AMA, the AAMC, the AAGP, the various specialty groups and individual medical schools have already had a try at seeking solutions to problems in this area with varying degrees of success or, I should say, lack of success. I am sure it is as obvious to the powers that be in Washington as it is to me that the key issue in the success of provision of increased quality and quantity of health care is really education. This includes not only the initial education (in medical school, residency and the post-doctoral area) in what constitutes good medical care and how it is best provided to all people in all situations, but also (and probably more importantly) the continuation of education in the whats and hows for the lifetime of the physician. The changing patterns of care and improved physician-to-physician relationships that will result from the medical care aspects of Title IX will provide the vehicle by which continuing education can occur. I have little doubt that those charged with the administration of proposed programs will insist on a strong education underpinning for them. If they do not, then they have missed a chance at providing strong therapy to one of the major illnesses in medical education today.

As new patterns of care emerge under the stimulus of Title IX, there will need to be changes in approach in residency training programs. New patterns of care will have to be backed by educational experiences which will permit individuals to fit easily in them. Down the road I can also envision greater governmental support for various specialty programs that are currently under-manned. This will have direct effect on the size of these residency programs. I can also see the possibility of the evolution

of bona fide residency programs in "family practice" which will bring about a degree of educational cooperation of current specialties that has not yet been accomplished within most medical centers.

I have already mentioned the greater involvement of paramedical personnel that will result in the medical care area. There will obviously have to be an increased educational effort to help produce these individuals. In addition to these quantitative considerations there will be (or at least should be) qualitative alterations in academic programs. If there is to be increased emphasis on the "medical care team", it follows that this concept should be brought into the education of the future members of these teams. Thus students in medicine, social work, clinical psychology, nursing, medical technology, physical therapy, etc. should have opportunities for interchange in their academic programs. This is going on to a limited degree in some university medical centers and not at all in others. Again here is an example of increased interchange that might well result from Title IX.

If I have sounded overly optimistic about the over-all implications of Title IX, it is because by nature I am an optimist. I would not like you to think, however, that I am sufficiently naive to believe these things are going to happen overnight or that they are going to occur easily. A great deal of turmoil and indigestion is going to result. It would be my hope that this would move slowly enough to permit the necessary adjustments without impeding the progress that has been accomplished to date. The marked changes between the original DeBakey proposals and the final Act hopefully suggest there is at least cognizance of what is being asked of all who are involved. One of the real concerns of many people is the manpower problem. In that all of the areas involved are short on personnel to carry out existing programs, great care will need to be exercised to avoid a significant drop in quality as we expend our efforts.

I realize I have rambled and said little of which you are not already aware. You asked for some of my thoughts about the implications of Title IX, and in order to get them to you quickly, I have given you a lengthy first-draft rather than anything approximating a finished product.

If there are points which you feel are unclear or need further elaboration, I will of course be delighted to try my best to be of help.

I enjoyed seeing you again at Philadelphia and Baltimore. I am extremely pleased at the direction the 1966 meeting seems to be taking. Ever since Williamsburg I have been concerned about the imagery of the Dean's Office and the lack of understanding of the faculty as to what is going on in Washington and its implications for them. It looks as though two birds may be killed with the same stone at Whiteface.

With best personal regards,

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Associate Dean

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John Russell

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