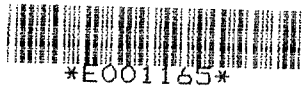
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P.O. Box 31431
Rio Verde AZ 85263-1431
August 5, 1991

Donald A. B. Lindberg, M.D.
Director, National Library of Medicine
National Institutes of Health
Bethesda MD 20894

Dear Don,

Please excuse my delay in responding to your letter of July 12, with its attachment of "QUESTIONS ON HISTORY OF RMPS." Serious illness in members of my family, which culminated in the death of my son-in-law in Morgantown WV recently, have completely disrupted my regular activities in the last few weeks. Things now appear to be back to a reasonable state of normality.

You will find enclosed my "off-the-top-of-my-head" responses to your questions. As usual with such inquiries, the questions are short and simple, but the answers are long and complex if one takes the time and trouble to think about them. I hope that I have not indulged in "overkill," and that what is provided will be of some use to you.

Incidentally, if anybody has tried to contact me by telephone and has failed to get an answer, the reason is the one given above. Dorothy and I have been traveling a great deal because of our family problems.

One of your earlier communications asked for suggestions on persons who might be invited to participate. Perhaps it is too late now, but some who should be considered if they have not already been contacted are:

Dr. Leonard D. Fenninger
Dr. Bland W. Cannon
Dr. Vernon Wilson

I can supply addresses and telephone numbers if you would like to have them.

If there is anything further I can do, please let me know.

Sincerely,

Bill

C. H. William Ruhe, M.D.

Enclosure

QUESTIONS ON HISTORY OF REGIONAL MEDICAL PROGRAMS

1. Why were RMPs established?

In my opinion, the purpose was primarily political. I do not mean that in a pejorative sense, but rather to indicate that the medical program was a part of the broader concept of the New Society. In this sense, it was deemed important to present a bold, imaginative program which would bring about major changes in the way health care was provided.

It seems clear that President Johnson considered the matter to be urgent. The time between the President's health message in February 1964 and the signing of P.L. 89-239 in October 1965 was amazingly short for such a major undertaking, and the first planning grants were awarded only a few months later. One can only assume that the orders were to "get something going in a hurry." Expedition of the legislation was aided by the national feeling of guilt and remorse related to President Kennedy's assassination and the impression that this would have been part of the Kennedy agenda.

I do not know whether the plan was "pre-formed" in somebody's mind (DeBakey?) but it seems likely that this was at least partially the case. In any event, it met the political requirements for boldness, imagination and major change, and provided the opportunity for a national public relations and promotion effort (today we would call it marketing) in an area which affected almost every citizen. Privileged or under-privileged, everybody was concerned about Heart Disease, Cancer and Stroke.

2. What were the major accomplishments of RMPs?

I believe that the most important thing accomplished was the development of cooperative arrangements among regional organizations, institutions and agencies; this was the central core of RMP. The degree to which it was accomplished varied widely from region to region; and, in general, the success of RMP was dependent upon how effectively the cooperative arrangements were established. There were some areas in which cooperation and coordination were minimal (e.g. Chicago) and in these regions, RMP never really got off the ground. The large cities, where there were several medical schools and major medical centers which had never cooperated well in the past, were the most difficult sites in which to achieve the RMP goals.

It is hard to say to what extent regional cooperation and coordination of health activities have endured since the demise of RMP, but it seems clear that communication was enhanced and subsequent efforts to bring people and organizations together to solve regional problems were made easier, at least for a while. Today the competition among health providers and health institutions has probably overridden any lasting benefit from RMP in this area. Your desire to recall the history of events leads me to suspect that you feel that the earlier cooperative arrangements have been all but forgotten.

RMP also brought about some improvement in the ways in which continuing medical education was organized and delivered. The most significant things were that RMP recognized the importance of continuing medical education and provided some funding for innovation in the field. To the extent that the various regions seized on this and took advantage of the opportunity, there were improvements and growth that continued for many years. I think it is fair to say that RMP gave c.m.e. a substantial boost forward.

Perhaps I am simply ignorant of it, but I was not impressed that RMP caused any significant difference in the ways in which medicine was practiced, other than that there was perhaps a heightened awareness of new technology and some increased funding for new "centers."

3. Why was RMP terminated?

Just as it was initiated for political purposes, so was it discontinued for political purposes; again, I use the term "political" not in the narrow sense of party politics, but in the broader sense of changes in the political scene. RMP had pretty much "run its course" in the sense of accomplishing its original political purpose. It no longer captured the imagination or support of the public, and it was time to change to different approaches (e.g. the designation of a separate National Cancer Institute.)

If one looks at it strictly from the point of view of whether it accomplished its objectives, it seems clear that the program was "doomed to failure" from the beginning. This does not mean that the program was faulty, but simply that it was vastly oversold, again for political purposes. President Johnson's health message presented an overblown picture of millions of people dying from heart disease, cancer and stroke, because of "the gap between the research laboratories and the bedside", and because of poor organization of the way medicine was practiced and health care was delivered (and I might add because of the great shortage of physicians).

While there was some truth in all of these allegations, they were greatly exaggerated. Furthermore, the impression was given, when the RMP legislation was passed, that there would be a great reduction in the numbers of people dying from heart disease, cancer and stroke. It should have been obvious that this was not likely to happen, and it was really unfair to judge RMP on that basis. Some did so, probably for their own political purposes.

Neither Congress nor the public was happy with providing support for the continuing education of rich physicians, and there was little enthusiasm for supporting that aspect of the program. Furthermore, both the new administration and Congress were looking for ways to cut back on the cost of health programs and it seemed logical (or was said to be logical) to merge RMP with the Health Planning and Hill-Burton legislation. After that, it was inevitable that funding would be reduced and then eliminated. The Hill-Burton legislation had really accomplished its purpose, and there was much less enthusiasm for building more hospitals, even in rural areas. The Health Planning legislation was never really understood by the health community, the general population or the Congress, and it was the kiss of death for RMP to be merged with it. I am sure that those responsible for the merger were well aware of that.

4. Other Impressions and Personal Reactions

One of the problems I had with the RMP legislation from the beginning, and even more with the Health Planning legislation, was the difficulty in determining exactly what was intended and what was likely to happen if the legislation passed. I was one of the AMA staff persons assigned to work with the AMA Department of Legislation to develop an AMA position. It was very difficult because the language was vague, and it was obvious that a great deal would depend on how the regulations would be written, or on subsequent amendments to the legislation once it had been passed.

Since the legislation was presumably based on The Report of the President's Commission on Heart Disease, Cancer and Stroke, we made frequent reference to that document in an attempt to determine "what was really on their minds." As noted in your Chronological Summary, the Commission Report contained "35 recommendations, including the development of regional complexes (poorly defined) medical facilities and resources." Most of the recommendations were not covered specifically by the proposed legislation, but the language was sufficiently vague in some areas that it might be extended to include the recommendations.

Eventually, after staff meetings between AMA reps (I was not included) and HEW/Commission reps, agreement was reached on modification of some of the language of the bill. I don't recall all of the compromises, but the ones which stick in my memory were those cited in your chronological summary: "The Commission concepts of 'regional medical complexes' and 'coordinated arrangements' were replaced by 'regional medical programs' and 'cooperative arrangements.'" These were significant changes and virtually dashed the hopes of those who saw in RMP a means of moving to a nationalized health plan for the delivery of care.

I am moved to comment philosophically that one of the problems with this legislation (and with a lot of other legislation over the years) is that it means different things to different people; i.e., various people, reading the same words, have different understanding of what they mean. It became evident in time that many people's expectations were not fulfilled by the course that RMP eventually followed.

This was abundantly clear in the meetings of the Review Committee (which George James chaired and I served on) Our task was to review the grant applications and make recommendations to the National Advisory Council. We were frequently confronted with misunderstandings of applicant groups, and occasionally by misinterpretations on the part of RMP staff. It was sometimes necessary for the Review Committee to reconsider what was really intended by the legislation, and to make sure that there was no gratuitous

extension of the law and its regulations to satisfy a broader agenda of some individuals.

The meetings of the Review Committee were long and sometimes tedious, and each member had a lot of home-work in reviewing applications. It was a good committee and the members worked hard, but there was occasionally some misunderstanding (perhaps only on my part) of what was intended by the legislation. I guess I was more sensitive to this than were others because of my position as an AMA staff member. We received frequent complaints at AMA headquarters from medical societies and individual physicians that RMP was overstepping its boundaries in some of its regional activities. Some of the complaints were valid, some were not; but there was always a frictional interface with the practicing profession, usually because of misunderstanding or misinterpretation of the legislation.