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REGIONAL MEDICAL PROGRAMS: IMPLICATIONS FOR THE COMMUNITY HOSPITAL

Address by Robert Q. Marston, M.D., Associate Director,
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Before the Association of Hospital Directors of Medical Education
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Gentlemen:

I am grateful for this opportunity to discuss with you the regional medical programs authorized by Congress to combat heart disease, cancer, and stroke. The particular focus of the members of this organization is on the community hospital environment, and I was asked to speak on the implications of the regional medical programs for the community hospital. I believe that the concept of the regional medical programs involves a very significant role for the community hospital. That role can best be understood, however, in the context of the overall purposes and objectives of the regional medical programs. I believe this approach would be most meaningful to you because the flexible nature of the program concept means that the specific impact of a regional medical program on a given community hospital will probably be quite varied, as a result of the emphasis on local initiative and planning. I would like to begin, therefore, with a general discussion of the purpose and background of this important new health program.

The principal purpose of this program is to provide the medical profession and the medical institutions of the nation greater opportunity to make available to their patients the latest advances in the diagnosis

and treatment of heart disease, cancer, stroke and related diseases. This overall objective is to be accomplished through the planning and establishment of regional cooperative arrangements among medical institutions, which can serve as the framework for linking programs of research, training, continuing education, and demonstration activities in patient care conducted by medical schools, clinical research institutions, and hospitals. The regional cooperative arrangements are intended to assure close contact between the development of a new medical knowledge and technique in the environment of research and teaching, and the delivery of high quality patient care in the hospital environment.

As you all know, during the past few decades, the accumulation of scientific knowledge of all types has proceeded at a geometric rate. The biomedical sciences alone encompass a body of knowledge so vast that no one man can master more than a fraction of the field. Only a few years ago, a doctor graduating from medical school was prepared for a lifetime of practice. Today's medical graduate finds that much of his knowledge is dated in three or four years.

The expanding support of medical research and training by the Federal Government in the years following World War II has been a major contributing factor in this knowledge explosion. Research conducted by university and other scientists using Government funds is now an established pattern of modern science--a pattern, if one can judge by results, that has proved highly satisfactory and workable.

Another aspect of the expansion and increasing complexity of medical knowledge has been the trend toward the overlapping of once rather distinct scientific disciplines. Not only are the biological sciences becoming increasingly interrelated, but the physical and social sciences have also become involved in the practice of medicine. Cancer research and treatment not only involves drugs, surgery, and radiation, but also electron microscope studies at the sub-cellular level and research into environmental carcinogenesis.

Modern cardiovascular research and treatment involves expensive and complex electronic equipment and the consideration of nutritional and emotional factors. This broadening of scope further complicates the task of achieving expertise in these disease categories.

It is similarly difficult for a single isolated hospital to attain and maintain a high degree of competence in these disease fields--competence, I mean, in diagnosis, treatment, continuing education and specialty training for its staff, and clinical research.

It is therefore this paradox of more knowledge than we can handle--especially knowledge which requires the interpretation of highly trained specialists--added to the high costs of modern medical care which brings us to the need for regional medical programs.

In March 1964, President Johnson appointed a Commission on Heart Disease, Cancer, and Stroke to study the dimensions of these problems, and recommend a program for a crusade against the "killer" diseases. The Commission heard the testimony of hundreds of expert witnesses, and in December of that year, the Commission made its report. After assessing problems, needs, and resources, the Commission made thirty-five recommendations for what it called "a national program to conquer heart disease, cancer, and stroke".

Many of these recommendations were to step up, extend, or otherwise modify existing Federal programs of research, training, and specialized community health programs.

However, the first three recommendations, which embodied the main thrust of the Commission's program, were concerned with the broad application, on a regional basis, of knowledge that had already been attained in the three disease fields, and the development of a framework for assuring close and continuous contact between the development of new knowledge and the delivery of its benefits to the patient. The Commission concluded that many thousands of lives were lost annually, not because it was not known what to do, but because existing knowledge was not being put to work. They believed that there was a need for immediate action in order to prevent further aggravation of the situation. The Commission also realized that a program to alleviate this problem would involve not only increasing

opportunities for the improvement of patient care, but also the extension of a fruitful environment for correlated activities of clinical research and specialized training, including continuing education.

In his Health Message to Congress in January 1965, the President urged implementation of the Commission's major recommendations. Congress quickly responded with bills introduced into both Houses for this purpose.

During committee hearings on the bills, many questions were raised. While not many parties denied that a gap did exist between medical knowledge and its application--although some did just that--much debate took place over the Commission's proposals to close the gap. Many persons had gained the impression that what the legislation proposed was a vast web of Federal research and treatment facilities. This web, these people feared, would be superimposed upon the Nation's existing medical capabilities, duplicating their functions and soon overshadowing them.

I can assure you that this was not the intention of the Commission nor of the implementing legislation. It soon became apparent that most of the misunderstanding was founded in problems of semantics. Through a series of amendments, changes were effected which largely eliminated many of these semantic difficulties.

The final version of the legislation, which was passed by the Congress to carry out the objectives I have discussed, provides an excellent mechanism for moving ahead in a realistic way with implementation of the program recommended by the Commission. I would like to point out to you some of the key features of that legislation and to stress some of the provisions of the law which I believe to be fundamental to a clear understanding of the nature of the program.

Those of you who have read the law have noticed that the wording of the law did not answer all of your questions about the specific content of a regional medical program and how such a program might affect your hospital or your function in the hospital. The breadth of the legislative provisions is the result of deliberate decision, for it provides the flexibility for innovation and adaptation in the development of a regional medical program which is particularly pertinent to regional needs, resources, and existing medical patterns. The flexibility does, indeed, represent a challenge to the initiative, resourcefulness and creativity of our medical institutions and organizations in putting together a cooperative effort that builds upon the best that region has to offer.

Another essential theme of the legislation is cooperation. The law provides that the participating institutions in a regional medical program will be linked together through a cooperative arrangement.

The term "cooperation" implies that free agents come together on a voluntary basis to achieve common objectives through mutual reinforcement. When viewed in this light, the threat that some persons see in the regional medical program diminishes and the opportunities emerge in clearer focus. The law provides that as a first step in setting up the cooperative relationships among medical schools, clinical research institutions, and hospitals, a local advisory group must be designated by the applicant to advise the applicant and the participating institutions in the planning and operation of a regional medical program. The law specifies that this advisory group will be broadly representative of the interested health organizations, institutions, and agencies in the region, as well as of the general public interested in the purposes of the program.

Grants can be awarded for planning of a regional medical program and for the operation of pilot projects for the establishment of a regional medical program. The provision for planning grants assures that initiative and creative ideas within the region can be translated into an effective plan of action for the development of a regional medical program supported by adequate data and the cooperative involvement of the relevant institutions and agencies. The pilot projects for the establishment and operation of a regional medical program will provide the basis for evaluation of the program concept and suggested modifications beyond the initial period of authorization. The designation of the initial operating activities as pilot projects emphasizes the congressional intent that the three years initially authorized represent an exploratory phase of the program.

The law provides for the appointment of a National Advisory Council on Regional Medical Programs which will provide the benefit of the advice and consultation of outstanding leaders in medicine and public affairs on the operation and development of the overall program. The Council will also review specific grant applications and make recommendations for approval or disapproval to the Surgeon General.

The law specifies that regional medical programs will not interfere with the patterns or the methods of financing of patient care, or professional practice, or with the administration of hospitals. It is quite evident that the intent of the law is to build upon and improve the already great medical capability of our institutions and medical personnel.

This brief sketch of the major provisions of the legislation has indicated the overall objectives and the basic mechanisms of this program. How will these mechanisms be translated into actual programs--bringing to more people the latest advances in diagnosis and treatment of heart disease, cancer, and stroke? I have already mentioned that the actual planning and implementation of program content will be up to the participating institutions. We do not have a grand Federal blueprint for a regional medical program which we will seek to impose throughout the country. We expect and, indeed, we will encourage a diversity of approaches which hold out the prospect of making a sound contribution to the objectives of the legislation.

I would, however, like to discuss some of the factors which you will be considering if you are involved in the planning of a regional medical program and the relationship of your institution to that program.

The definition of "region" for the purposes of this program is left flexible in the legislation. We would expect that a proposed region be functionally coherent. It would follow, where appropriate, existing relationships among institutions, and existing patterns of patient referral and continuing education. It would encompass a sufficient population base for effective planning and use of expensive and complex diagnostic and treatment techniques, which often require a certain patient load for optimal efficiency. The clear definition of a region and its relationship to adjacent regions will emerge from the planning process at the regional level. Regionalization in the health field, as I am sure most of you know, is not a new concept, and existing regional patterns can serve as a guide and foundation for the development of the new regional program. In many areas of the country such patterns are already operating with various institutional relationships and program scope. One example often mentioned is the Bingham Associates Program in New England, which has built up relationships over the past thirty-five years between the New England medical center in Boston and community hospitals in Maine and other New England states.

The number of regional medical programs throughout the country will, of course, be a derivative of local initiative and planning and the future evolution of the total program. I would urge that you view the full development of a given regional medical program and the emergence of national coverage by regional medical programs as an evolutionary process over a number of years. The current authorization expires on June 30, 1968, and before that date the Congress will consider extension of the program and modifications suggested by the administration. Some of the worries which have been expressed to me about the program result from a fear of the effects of crash implementation. I hope that I have made clear that our intent is an orderly development based on sound planning--planning that considers the current limitations and future availability of trained personnel and resources and the continuing evolution of a regional medical program in accordance with changing needs and further medical progress.

One of the types of activity which should benefit substantially from the development of regional medical programs is continuing education. Many of the groups throughout the country which are doing preliminary planning are excited about the prospects of being able to use the regional medical program as a framework for more effective continuing education programs, not only for physicians but also for other medical personnel. The community hospital and the directors of medical education in the hospital setting should play a vital role in these developments.

The continuing education of physicians was cited by the Joint Committee on Continuing Medical Education as the most important problem facing medical education today. The report of that committee, Lifetime Learning for Physicians, also stated that there is a serious gap between available knowledge and application in medical practice. In the implementation of the proposals of the Joint Committee it would seem that the regional medical programs will offer an excellent framework on the regional level. Reporting on the regional medical programs' legislation, the House Committee on Interstate and Foreign Commerce noted that the regional medical programs could provide the continuity which is essential for any effective education program. "A well developed program with continuity between the separate elements will enable the practicing physician to make the most effective use of his valuable time by insuring that each time he participates in the program he will be reenforcing his earlier education experiences. The legislation will help to provide the staff, facilities, communication systems, and curriculum planning which are necessary for the development of a continuing education program."

By using the community hospital as an educational resource, the regional medical programs would assure that the physician did not have to leave his practice and go off to a distant medical center for an extended period of time. By establishing continuing relationships between the medical center and the community hospital, the regional medical programs would provide educational activities that were integrated with the activities of the hospital and readily accessible to the

practicing physician. Within the community hospital the education programs can be designed to have real and immediate relevance to the problems faced by the practicing physician in his daily activities. All of these educational activities will be enriched by the constant interaction among the medical center, the community hospital and the practicing physician. This interaction will help to maximize the contribution of each element of the medical service team in bringing the latest advances of medical science to the benefit of the patient.

The development of other elements of a regional medical program is open to imaginative thinking about the problems raised by the complexities of diagnosis and treatment of heart disease, cancer, stroke and related diseases. Among the ideas which are already being discussed, in addition to continuing education activities, are the provision of expensive and complex diagnostic and therapeutic equipment on the basis of a plan to insure their efficient use, support for the trained team which is essential to the utilization of such equipment, the development of electronic communications networks for diagnostic and educational purposes, the provision of regular arrangements for patient referral, the exchange of personnel between the medical center and the community hospital, and the extension of opportunities for clinical and epidemiological research. We hope that the program will stimulate new approaches to the problems and opportunities created by the impact of modern scientific medicine.

The regional medical programs also hold great promise for blurring the distinctions between "town" and "gown", by opening up two-way channels of communication between academic and practicing medicine. It is heartening to see that even at this early stage of the programs' implementation there is much evidence that just this sort of thing is actually happening all over the country. We have been pleased at the progress in preliminary planning which is being made in many areas. Institutions and organizations which have not maintained effective communication previously are now sitting down at planning conferences and discussing how each can contribute to the development of a regional program. Serious interest has been expressed by institutions and groups located in every state of the nation. This widespread initiative gives us the feeling that the broad scope of possibilities under the program will be explored and developed.

We are proceeding as rapidly as possible with the administrative implementation of this legislation. A Division of Regional Medical Programs has been established within the National Institutes of Health to administer the program. When we recruit additional staff for the Division we intend to maintain close contact with the planning activities around the country and to provide each planning group with information on activities under way in other regions. The National Advisory Council has been appointed by the Surgeon General and held its first meeting in late December. The outstanding qualifications of the Council members assure us of expert advice and assistance in the development of program policies and the approval of sound application.

The draft regulations governing the program are being processed, and an early draft of those regulations was discussed with the leadership of this organization and other national medical and health organizations. Application forms are being developed and will be distributed to interested institutions and organizations. \$25 million has been appropriated for this fiscal year to support planning grants and early operational activities. The challenge of regional medical programs, however, is not limited to what can be accomplished with these Federal funds alone. It is intended that this support will be a base of departure for plans and programs which will make the best possible use of existing resources, institutions, and skills.

I hope that in these remarks I have conveyed to you my conviction that this program presents challenges and opportunities for significant progress in the battle against disease. This new program is in the continuum of existing trends--the dynamic impact of scientific research, the high degree of complexity in specialization in the resulting new diagnosis and treatment techniques, and the challenges of effective communication among all elements of our medical endeavor. The members of this organization occupy excellent positions to assist in answering the challenges and exploiting the opportunities, for the community hospitals are an indispensable element of any program to bring the benefits of scientific progress to the victim of disease. I look forward to a continuing relationship with this organization as we pursue our common objectives. I thank you.

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