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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Executive Session

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

Rockville, Maryland
Tuesday, 3 August 1971

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Public Health Service

Health Services and Mental Health Administration

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NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

Conference Room G-H
Parklawn Building
Rockville, Maryland

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P R O C E E D I N G S

DR. MARGULIES: We have some issues to deal with which have some wide implications in terms of the whole RMP mechanism and they justify a little closer attention than we might have in what we call the open session.

The executive session is one from which we will have reports if they seem reasonable to report and not otherwise. We'll use your judgment about what should be done.

Let me get to the first one of primary concern, and I'm going to ask Sewell Milliken to play a particular lead role in this discussion. This has to do with the Ohio Regional Medical Programs. Now, to bring you up to date on that particular subject, there are four programs which operate in the State of Ohio. One of them, the Ohio Regional Valley Program, has most of its activity in the lower valley but it does include Cincinnati and some of the others so it is in addition to its major concern.

The other three programs, which are Northwest in Toledo, and Northeast in Cleveland, and North in Columbus, are pretty much confined to the State of Ohio and over a period of time all three of the latter programs have been the source of real concern to the Council and to the staff.

They are, to put it briefly, quite inadequate, and they range from fairly bad to inacceptable, and that's not an exaggeration I'm afraid. The Ohio State Program is sort of

1 plodding and unimaginative and very much tied in with fairly
2 traditional interests of the medical school. The Northwest
3 Program in Toledo has just never been able to achieve anything.
4 It has had extensive criticism by the Council. It has been
5 put on notice time after time because it is performing so
6 badly. It has had problems with the coordinator, with the
7 regional advisory group, with the kinds of programs it has
8 developed. It has been mismanged and in general it has
9 accepted in our discussions the fact that it's in bad trouble.
10 The one in Cleveland is a program which became
11 operational a little more than a year ago, as I recall. It had
12 in its beginnings a very vigorous and fairly dominating
13 coordinator who soon after it became operational left for
14 another activity, and they have in that period of time not been
15 able to locate a coordinator to take over the activities and
16 they have managed as well as one can under those circumstances.
17 But among other problems in the Northeast Ohio one -- that is
18 the one in Cleveland -- is the re-emergence of some old internal
19 problems in Cleveland between elements of the medical community
20 which continue to paralyze any decision-making process.
21 At the last meeting of the Council we were urged to
22 get together with the people in Ohio and have them reconsider
23 some way in which this could be redesigned into an effective
24 program for the State of Ohio without having three ineffective
25 activities going on.

1 We did have a meeting with representatives from all
2 four programs and that was here in the Parklawn Building, and at
3 that meeting were representatives from the grantee agencies,
4 from the regional advisory groups, and the coordinators. There
5 was uncertainty at that time, and I think some uncertainty
6 remains, about the Ohio Valley RMP aspect of it, but it was
7 quite clear that those people that came from Cincinnati had no
8 interest in moving from the present arrangement with the Ohio
9 Valley RMP into a new arrangement, regardless of what that
10 might have been, in the State of Ohio.

11 There was a variety of attitudes expressed by those
12 who came from Northwest, Northeast and Ohio State, but they
13 were influenced considerably by the sense of determination which
14 we had which suggested to them that they had a number of
15 choices but it would all come out to be a consolidated program
16 of some kind.

17 We gave them some figures about that and pointed out
18 some of the costs that were involved in multiple programs and
19 reminded them that they really had not done very well. I helped
20 draw their attention to it by giving them six months of funding
21 so that they could consider some of the alternatives which
22 appeared to concentrate their interest considerably.

23 Now, from that, they drew the conclusion that they
24 should meet together in Ohio; that they would consider the
25 potentialities in another kind of an arrangement; and that they

1 have done.

2 Now, one of the fortunate things which was going on

3 at the same time is that Sewell Milliken is the Director of the

4 CHP in the State of Ohio and when this began we didn't know he

5 was going to go on the Council -- anyway, he didn't know -- and

6 so he was a fairly free agent in this and sort of a neutral

7 figure in the activities which were going on, and quite by

8 coincidence, John Cashman, who has until very recently been

9 Director of the Community Health Services here in HSMHA, has

10 resigned and is going to Ohio in the State Department of Health.

11 So we had some interested, knowledgeable people

12 involved who occupied a very special kind of position. We

13 agreed that when they met we, the RMPS, would stay out of it

14 and that we would be on hand to provide any kind of information

15 or backup they wanted but the decision-making process was in

16 their hands and we would look forward to what came out of it.

17 Now, unfortunately, at that first meeting which we

18 held here, Sewell ran into airplane difficulties so he got in

19 during the afternoon and missed the initial session, but he

20 has been a part of the one that followed and they had a meeting

21 out there and this led to a second meeting which took place a

22 week ago Sunday, July 28.

23 So what we would like to have you do now, if you will,

24 is bring us up to date on what happened and what sort of issues

25 we're likely to be facing.

1 MR. MILLIKEN: In this folder that you have, if you
2 go down through it you will find the minutes of the Ohio RMP
3 meeting held on July 28, 1971. That's all of the critical
4 reference that all these other conclusions will lead to.
5 First of all, I'd like to say, probably unnecessarily
6 so, this is a very traumatic thing for the RMPs in Ohio to go
7 through and particularly the RAG. I understand that the RAG in
8 Cleveland has not yet accepted this change in concept, but
9 the Cleveland group is proceeding in spite of this and I'm sure
10 they will get along.
11 The critical issue after this meeting, as a result
12 of this meeting of the 28th, focused around who the fiscal
13 agent would be. Of course, the Ohio State people felt they
14 could play this role and the Ohio State Medical School can play
15 this role, and this was not acceptable to any of the other
16 RMPs for historical reasons.
17 As a result of this, there were two alternatives. One
18 was that the Cleveland people -- item number four on this
19 letter, the minutes, is one of the alternatives that was dis-
20 cussed in the halls, and this was that the Northeast Ohio
21 Regional Medical Program is a non-profit corporation and could
22 be moved to Columbus -- change it a little -- and still continue
23 under its previous incorporated status. This got a lot of
24 discussion.
25 The information they received from Dr. Margulies to

1 look at some of the other states and some alternatives of doing
2 this led them to Kentucky, where the University of Kentucky
3 Research Foundation has been the fiscal agent, and they studied
4 this and two or three of them met Paul Warren(?) somewhere in
5 Illinois and spent a day with him and discussed this; and as a
6 result, the serious discussion centered around the Ohio State
7 University Research Foundation under similar arrangements that
8 the University of Kentucky Research Foundation has been
9 operating.
10 It took a lot of talking, but there was finally
11 agreement on the 28th that they would all go this route. Now,
12 the Ohio State people have practically certified -- not under
13 oath, but almost -- that there is no direct relationship between
14 the research foundation and the university, but the others do
15 not quite trust them.
16 DR. DE BAKEY: The university?
17 DR. MILLIKEN: Yes. However, they are willing to go
18 that route but there is great concern about the fact that Ohio
19 State could end up being the RMP, which the others -- as Dr.
20 Margulies put in his letter to them, he thought that the federal
21 office and this Council would question any arrangement whereby
22 any of the existing RMPs took over the others.
23 There was a little disagreement on this meeting on the
24 28th as to who was the chairman. They asked Dr. Pace to convene

25 the meeting -- he's from Ohio State -- and he assumed he would

1 be chairman. But after he started the meeting he was shown
2 very quickly that they were going to elect their own, and so
3 Dr. Fishbein ended up as chairman for this first meeting.
4 Now, at the next meeting, they have again asked Dr.
5 Pace to convene it. They are meeting tomorrow and take this
6 one more step. I imagine they will rotate the chairmanship of
7 this group.
8 Now, you might go to enclosure number two, which is
9 this long flow chart, and starting, as I guess one is supposed
10 to with such charts, go to the extreme right with their deadline
11 of February 1, their target date for the Washington RMPS review;
12 and backing up from there, I think this is one of their critical
13 questions, Dr. Margulis, as to whether this February 1 date is
14 correct on that basis for all that has to be done here to meet
15 the timetable.
16 Backing up from that, this January 15 is rather
17 routine. December 1 is the CHP review and comment which I don't
18 believe presupposes any problem. November the 15th, the
19 proposal review by the interim Ohio Advisory Council will be
20 complete. The October 1 deadline is the real critical one
21 because all of the RMP areas will have to put together their
22 various different concepts of this, and this leads me to a
23 question that has not come up yet by this group, and some of us
24 who have been talking about it in advance feel that it might be
25 well to have some mechanism wherein it would be possible for

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1 some leadership other than that now currently operative in each
2 of the four could rally around.
3 One such activity would be that each of them, if it
4 were acceptable and feasible, could contribute money into a
5 central pot to employ an interim person, or another alternative,
6 as was suggested to me today, is that they might get a loan of
7 a very capable staff person maybe from this office who could
8 be the rallying point around which each of the current organiza-
9 tions could get an advance and early start towards putting this
10 together organizationally and program-wise so that no one of
11 the existing people now involved has to run the gauntlet and
12 bring in all the past problems. That might happen, but this
13 has not been discussed by anybody in these RMPs.
14 DR. DE BAKEY: Is there enough vested interest on the
15 part of the various groups to make it so tramatic that you'd
16 almost have to destroy it in order to start over?
17 DR. MILLIKEN: I think just after the meeting of the
18 28th this was the feeling, but as a result of that meeting and
19 as a result of the communications that's been on-going since, I
20 think they all feel that this is feasible now.
21 DR. MARGULIS: One of the interesting kinds of
22 releases of pressure in this came about during the initial
23 meeting when the people from Cincinnati were disclaiming any
24 interest in moving from where they were, the point being that
25 they had been able to maintain some sense of local integrity

1 although they were part of a Kentucky program; and I pointed out
2 the fact that the same thing can happen in Columbus and in
3 Cleveland and in Toledo, that they can be in a single state
4 program and still have a sense of local purpose by subregiona-
5 lizing. Cincinnati was a good example. I think they are
6 beginning to recognize that they aren't giving up everything
7 but actually can retain something.
8 You know, that point that you just raised, Sewell,
9 of the critical issue of deciding on some common goals and
10 priorities, also brings up the other issue which you really
11 haven't dealt with and have to, because in essence what we're
12 doing is combining weaknesses in this program unless we do
13 something extraordinary to bring them together and make it a
14 stronger program; and I think almost of necessity there's going
15 to be some sort of outside infusion necessary at the point where
16 they're deciding exactly what is it they're going to be with
17 this combination.
18 DR. DE BAKEY: The amazing thing to me about this is
19 that they are tremendous resources in the State of Ohio, cer-
20 tainly a talented pool of medical personnel, and why they can't
21 find leadership to energize a program like this into a good,
22 strong program is difficult for me to understand.
23 DR. MARGULIS: Sewell, you're there in the A agency.
24 Do you have some comment?

25 DR. DE BAKEY: I was concerned that it was sort of

1 too much selfish vested interest. Of course, you have some
2 traditional polarization anywhere you go. You know, there's
3 no place in the country you won't find some polarization, but
4 that hasn't prevented a good, strong RMP program. In fact,
5 some places where it's been strongest --- where they have
6 developed a strong RMP program has been where there's been the
7 stronger traditional polarization.

8 DR. MARGULIS: They kept talking about the vast
9 differences within the State of Ohio and I pointed out to them
10 that they are much greater in other states, that almost every
11 place we work has great differences from one area to another,
12 and some manage and some don't.

13 DR. DE BAKEY: That's right. One of the big
14 differences of the State of Ohio from other places is the
15 talent of medical personnel they've got.

16 DR. MERRILL: Is this essentially a "town and gown"
17 thing? Is everybody against the university or are they all
18 against each other?

19 DR. CANNON: I think there are several things. One of
20 them has been leadership. It's been over a year since they
21 decided the leadership in the Northwest, I believe it was,
22 needed to be changed. Mike, you're the one -- as I remember
23 that now, I said "Fire him," and you said, "No, let him work it
24 out."

25 DR. DE BAKEY: That's right.

1 DR. CANNON: And we sent a task force out there and--

2 DR. DE BAKEY: I remember that very well, Bland, and

3 I have to --

4 DR. CANNON: We never did get rid of him.

5 DR. DE BAKEY: I agree with you we didn't, because I

6 thought they ought to do it themselves, and I still think that

7 was the right thing to do, but obviously it didn't work.

8 DR. MILLIKEN: I think part of the problem that was

9 built into this, some of us tried to do something about this

10 two years ago -- there was unfortunate overlap -- two or three

11 county overlap between each of these programs and when we

12 discussed this two years ago or more with the coordinators --

13 we have been meeting together ever since the program started --

14 they all said "Well, this is no problem. A county can have the

15 best of all worlds. They can get some particular thing from one

16 RMP and something else from another." Well, unfortunately, like

17 everything for everybody, there's another side; and the other

18 side was that it's seeded distrust between -- a little bit

19 between "town and gown" and in a couple of areas -- in Lima,

20 Ohio, for example, there was some physicians who graduated from

21 Ohio State and some that graduated from Michigan, and they were

22 pushing their own schools and this built in another controversy.

23 So that some of us shudder to see the review and comment coming

24 down the pike with this county overlap.

25 As somebody told me just before I came in here, in the

1 city of Dayton, there are a great many people, physicians
2 included, who think Dayton isn't in either, but actually it's
3 in two; but you can't convince them that they belong to either
4 because there's been no one there. It's created a vacuum
5 because there's nobody there pushing. Those that are for
6 Cincinnati push it and those in Ohio State push it.

7 DR. MILLIKAN: As you see the emerging design
8 administratively, is it to go the California route with a
9 separate, simple, relatively small office and then area one,
10 area two and area three, in all probability?

11 DR. MILLIKEN: Right.

12 DR. MILLIKAN: I saw the definitions there.

13 DR. DE BAKEY: The thing that concerns me about that
14 is that I'm really more worried about how that would effect a
15 real change in strengthening the activities of RMP within the
16 various areas.

17 One of the main reasons that the thing works so well
18 in California I think is because of the leadership they have.
19 They have got very strong leadership there and the people rally
20 around their leader, both in the areas as well as in the central
21 administrative office. They have respect for them and it works
22 well. But you can't just take this same group and give them
23 another designation and say it's going to be comparable to
24 California. It is now, in a way.

25 DR. MILLIKAN: I didn't mean to imply that. In the

1 first place, you would have a new RAG and the new RAG might
2 consist of the deans of medical schools and people from the
3 Heart Association and Cancer Society. It would be a new RAG
4 overseeing the entire phenomena as in California, if one went
5 that route, and you might engender in that kind of new RAG some
6 sense of responsibility toward the subdivisions. In other
7 words, there is area, one, area two and area three, which is
8 the kind of thing that is going on out there. Now, it is
9 perfectly correct that sooner or later you have got to infuse
10 some leadership in each of the subdivisions or you're dead, but
11 at least there would be the new RAG concept.

12 DR. MARGULIES: I think it would be a great mistake
13 to move to some sort of balkanized concept in which they still
14 have their individual function but work together at some central
15 point. We really have to replace what is there but give them at
16 the same time a sense of purpose within the total RMP.

17 I wonder how much value there might be, when they get
18 to the point of considering the way in which they want to functi
19 together, in getting consultation -- and I really haven't
20 thought about this -- from some other coordinators who have
21 been working on the statewide basis and who have some under-
22 standing of how this kind of thing functions, no one with any
23 nearby geographical relationship but some distance away.

24 DR. DE BAKEY: I must say I like the idea Sewell
25 proposed of having someone come in there. I don't know how

1 feasible this is, but it certainly would seem to me it would
2 make it more practical to move them if there was somebody that
3 could come in who would be objective and in a sense nonpartisan
4 in his view and he has no axe to grind and he's not related to
5 any group and they would have to respect him by the very fact
6 that he obviously would be a person you would send who knows
7 his business to come in there at least on an interim basis and
8 be the regional director and sort of get them started
9 organizationally and constructively and infuse in them some
10 feeling of trust for the program. I don't know that you're
11 going to be able to do it with the people they have got.
12 DR. SCHREINER: Did the task force explore that
13 possibility of having it disappear and let it go and take one
14 from Pennsylvania or something?
15 DR. MILLIKEN: That was not realistically explored.
16 They gave it up real quick.
17 DR. EVERIST: Is this the first consolidation that
18 we have had? We have had some separations.
19 DR. MARGULIS: I think so.
20 DR. EVERIST: We have had no consolidation?
21 DR. MARGULIS: I think so, and we are going to lead
22 to another discussion hereafter of another couple of areas
23 because this is not just an Ohio problem. We have the problem
24 to consider elsewhere.

25 DR. CANNON: It never has been clear to me as to who

1 has the coordinating responsibility, the grantee?

2 DR. MARGULIS: Yes.

3 DR. CANNON: Then the key to this is the grantee,

4 because you're going to have to fire some people and that's the

5 whole thing. The good programs that we have got you can focus

6 real quickly on is because of local leadership, the regional

7 leadership. Now, you have got to fire some people.

8 If you're going to accept this foundation as the

9 grantee you have got to know beforehand that they are willing to

10 reshuffle and change the personnel because if they're not

11 willing to do that we're going to have the same problem no

12 matter how we merge them or divide them or anything else, and

13 that's what I think -- if you once get over that hump, I think

14 you've got it made, whether you have four or three or two or

15 one.

16 DR. MARGULIS: That's a good point.

17 DR. CANNON: But we haven't yet -- you know, we tried

18 to find out who hires and fires the coordinator and it's always

19 been talked about under the table, but no one has ever come out

20 and said who is responsible. Can a RAG group?

21 DR. MARGULIS: No. It's the grantee.

22 DR. CANNON: So I can see why they wouldn't want Ohio

23 State as the grantee, you know. I can see that. I would think

24 it's up to us to decide whether the grantee that's being

25 considered there is an appropriate agency that will make the

1 decisions that have to be made.

2 DR. MARGULIS: Do you have any idea at this point of

3 how that would be decided? Because you have a corporate body

4 which is the fiscal agent, but then the question after that is

5 how do they make up the body which is going to direct their

6 affairs? How is it composed? And that's the key to who they

7 choose.

8 DR. MILLIKEN: There's a paper in here with the

9 suggested makeup of an interim state RAG. They go in with an

10 interim advisory committee which would then, with some changes,

11 become the final one. Membership would consist of an equal

12 number of representatives from each of the four RMPs, 12 members

13 represent each district office, representatives from each of the

14 four RMPs shall be selected by that region which is part of this

15 whole built-in thing.

16 DR. DE BAKEY: That's a RAG you're talking about now?

17 DR. MILLIKEN: That's right.

18 DR. DE BAKEY: The Ohio Research Foundation?

19 DR. MILLIKAN: Who is that going to be and what kind

20 of a board and so forth?

21 DR. CANNON: Who are "they?"

22 DR. MILLIKEN: There's a letter here that doesn't

23 answer all those questions, but --

24 DR. KOMAROFF: Hasn't it been true, though, that when

25 coordinators have been fired that the RAG really gets together

1 with the grantee and the grantee -- it's nominal that it's the
2 grantee that does the firing, or the hiring for that matter, but
3 it's really the responsibility, historically, of the RAG?
4 DR. MARGULIS: Well, it has and it hasn't, Tony. It
5 really depends on the working relationship. We'll get to
6 Susquehanna Valley in a minute and you will see that it's not
7 necessarily true. That will happen when the RAG is functioning
8 well.
9 In these circumstances, however, it would have to be
10 without benefit of RAG because almost by the nature of it the
11 RAG would be dissolved, the RAGs, the separate ones.
12 DR. MILLIKEN: The five points in this letter that's
13 with your material sort of spells out their recommended
14 procedure. It's from Stephens, who is the Director of this
15 Research Foundation. They are trying to move from the
16 periphery to the center in a series of steps is what they're
17 trying to do, which assures them all they will continue to have
18 a voice in the changes. This is the big issue and they want
19 visibility and they even talked about phasing -- doing this in
20 phases, which has some merits, too. But they have gone sort of
21 to the interim board with the expectation that this board will
22 have real clout and will be able to help determine the policies
23 of the fiscal agent.
24 DR. MARGULIS: It would seem to me from what you said
25 that so far as our negotiating position is concerned that the

1 interim board and then the fiscal agent are the points on which
2 we can act and the people to whom we can talke and clarify some
3 understandings with.
4 Northwest Ohio is really basically very passive about
5 it. They are perfectly willing to join any place because they
6 know they're in deep trouble. There's a big difference -- or
7 there was a big difference -- I don't know whether it has sur-
8 vived but I would imagine it has -- between Fred Robbins and
9 Charlie Hudson in Cleveland as to how this would function, with
10 Charlie performing in characteristic manner. He doesn't want
11 any part of it.
12 DR. MILLIKEN: He has sort of stepped out as a result
13 of the meeting on the 28th. He declined to discuss it and this
14 probably would be his posture.
15 DR. MARGULIES: So far as I can tell, if it's
16 agreeable with the Council, the extension of the support for
17 this, as long as they have gone really quite a long ways, to
18 allow them to come in with a February date is very reasonable.
19 I think that's quite good and shows a definite kind of plan
20 and we can begin to work with the interim committee and then
21 with the fiscal agent and involve Council and other staff
22 people that seems appropriate.
23 DR. MILLIKAN: I move that the Council go on record
24 as supporting that initial plan.
25 DR. KOMAROFF: Second.

1 DR. MARGULIES: Any further discussion?

2 DR. EVERIST: This includes sending a man from staff

3 there?

4 DR. MARGULIES: Yes. We will begin to work directly

5 with them on a staff basis now that they have gelled their

6 plans. Any further discussion?

7 (No Response)

8 DR. MARGULIES: All in favor say "Aye."

9 ("Ayes")

10 DR. MARGULIES: Opposed?

11 (No Response)

12 DR. MARGULIES: Now, let me move you for a moment --

13 we are going to have to talk about New York before the afternoon

14 is over, but let's have a reprieve from that for a second and

15 talk about Susquehanna Valley RMP; not that that makes anything

16 any easier, but at least you need to be brought up to date on

17 it.

18 DR. ROTH: What's a reprieve about that?

19 DR. MARGULIES: Well, you're quite right. You may

20 recall that at prior meetings of the Council the level of

21 enthusiasm for Susquehanna Valley RMP has been very close to

22 that of the Northwest Ohio RMP. It's been a program which has

23 been in considerable difficulty and there was a very interesting

24 discussion about that program the last time because in the

25 review of that RMP it was apparent that it really did have some

1 real assets, that it had potentials for being a good program.
2 It had an extremely high level of involvement with practicing
3 physicians. The staff of the RMP, although it was young and
4 inexperienced and derived primarily from non-health fields, had
5 some real vigor and imagination, but there were some major
6 issues that had interfered with it being a successful program.
7 There was a general impression that the state medical
8 society had totally dominated the RMP and the staff and the
9 working practices, and there was great concern over the fact
10 that they had never had any professional leadership in that
11 program; that nobody with any health background or any
12 experience in the health field had been in the position of
13 coordinator or in any administrative capacity and that, indeed,
14 the lay director of the program had formerly been on the staff
15 of the Pennsylvania State Medical Society and was sort of
16 loaned to the RMP initially and then remained there permanently.
17 He was not the executive secretary. He had a lesser position
18 with the Pennsylvania State Medical Society.
19 These concerns with the program had been transmitted
20 to Susquehanna Valley on more than one occasion. So it was
21 decided last time that they should be given an opportunity, if
22 it appeared to be appropriate, to have an increase of funding
23 with the understanding that this was based upon a clear
24 declaration of new direction and new effort on their part. It
25 would be tied to that kind of an understanding.

1 So we had them come in and on that occasion we had
2 representatives from the Hershey Medical School, from the
3 Pennsylvania Medical Society, from the Regional Advisory Group,
4 from the Board of Trustees of the Pennsylvania Society, as well
5 as the Executive Secretary of it, and the coordinator.
6 In the process of that discussion, there was a
7 copmlete rejection of th4 constant criticism that the medical
8 society had run the affairs of the RMP and they said this is
9 simply not true, and the coordinator denied that it was true,
10 and so what we had was one report vying against another, and
11 that didn't help matters very much.
12 However, during the discussion, they asked me directly
13 if it was my judgment that the coordinator who was sitting
14 there should be replaced by someone who had a medical background
15 and my response was "Yes" and he resigned; so he is no longer
16 the coordinator and they have an interim arrangement and they
17 have a search committee now to locate a coordinator who has
18 medical competence and a medical background to go into the
19 program.
20 We also had a discussion of the problems there which
21 related to the medical school and you may recall that there was
22 the feeling that the relationships between the RMP and the
23 medical school were tenuous at best. Well, I tried to press the
24 dean a little bit to see what he thought the relationship should
25 be and I asked him, "Well, what do you think RMP could mean to

1 your medical school?" And to capsulate it, his answer was,
2 "Well, they could use some new angiocardiographic equipment,"
3 and this was the general pattern of his response.
4 Well, I tried some other tacks, you know. He was
5 concerned over the fact that they had started with the idea of
6 making this a family practice kind of medical school but he
7 kept bragging about myocardial metabolic studies, and he said
8 that the family practice unit was being swamped by people in
9 this area who saw it as a good place to get medical care, which
10 made it very difficult to use it for teaching purposes if it
11 was going to provide that much service. I said, "Well, do you
12 think it might be a reasonable thing if the RMP played a role
13 in working with the local family practitioners to try to replan
14 the distribution of health services so that you peripheralize
15 the activities of the medical school and created some balance?"
16 And he said, "No, that would be improper for the RMP because
17 that would be interfering with the way individual practitioners
18 functions and they were a very conservative group," which is
19 what I always hear when somebody doesn't want to do something --
20 "We have a very conservative medical society," they say.
21 So I got the feeling out of that that the relationship
22 with the medical school are just not likely to prosper under any
23 circumstances. It doesn't seem to be designed for that kind of
24 linkage. So what we have up to the present time, unless this
25 is being misread, is an agreement on the part of the medical

1 society that they will seek out another kind of an individual
2 to act as the coordinator.
3 The chairman of the Regional Advisory Group under-
4 stood the RMP concepts and was very helpful. I think he's the
5 chairman-elect. He's a physician. But we are still left in an
6 uncomfortable position because the relationship between the
7 agency and the RMP remains what it was initially. The lack of
8 a medical school which is really going to be tied in with the
9 RMP remains a problem, and we have only gone partway toward the
10 resolution of this issue.
11 DR. DE BAKEY: It seems to me, there again, it's the
12 lack of leadership. I can understand the lack of imagination
13 on the part of the dean. You almost have to have that trait
14 to be a dean, so that's not unusual. But there is, it seems to
15 me -- if you have leadership on the part of the Regional Medical
16 Program coordinator, then he could get around this kind of lack
17 of imagination on the part of the dean and actually bring in
18 faculty members, many of whom I know would be very anxious to
19 take advantage of the opportunity of the regional concept there
20 and that would provide them with really a rich outlet from their
21 standpoint in training, and at the same time add considerably
22 to the strength of the Regional Medical Program in the community
23 and particularly with the doctors in the community.
24 So, again, it seems to me you come right back to the
25 same business, and that is the lack of leadership and someone

1 fired up with the concept who will not allow the dead hand of
2 the dean to interfere with what he can do, and this is what's
3 happened.

4 DR. ROTH: I was simply going to say that as long as
5 this is an executive session and all in the family, that it's
6 very difficult to be comfortable with people in organizations
7 that are undergoing convulsive disorders themselves. This is
8 about the situation with Hershey Medical School, and I think
9 it's a mistake to expect to correlate into an RMP program a
10 young medical school which is having severe financial problems.
11 They have had their own plans from the Milton Hershey Foundation
12 totally upset, which turned out not to be enough millions, so
13 they have had to give the school over to Pennsylvania State
14 University. They set out to be a new humanist-type of medical
15 education and very promptly got themselves embroiled in an
16 unsolved argument with all the general practitioners in the
17 area of Hershey, Pennsylvania and so on by a very undiplomatic
18 suggestion of the dean that these general practitioners could
19 bring their patients into the hospitals and be members of the
20 staff under two conditions: the medical school collected all
21 the fees, charged 20 percent for administration, and exacted an
22 additional 25 percent voluntary contribution to an academic
23 enrichment fund. So the practitioners find their fees dis-
24 counted 45 percent from the moment they start.

25 Then, on top of this, their first graduating class

1 was 24 students dedicated to family practice and only one of
2 them signs up for a family practice post-graduate education.
3 The other 23 are going on into orthodox residency programs.
4 That's the medical school's problem and they are a fledgling
5 school. They are just now appointing heads of important
6 departments. So they can't contribute much.

7 Now, on the medical society side, you had an employee,
8 a third-range lay employee, who wasn't doing a very good job
9 for the medical society and it looked like a real good place
10 to put him, where they needed a coordinator on a program, and
11 he hasn't been any more successful in this. The best thing that
12 has happened is to have him voluntarily resign, because you
13 have got a soft-hearted director there that didn't have the guts
14 to fire him.

15 I think we are now at the fringes of a new day, but
16 if they can get a strong director of the program -- I agree
17 that they have all the resources and they ought to let the
18 medical school tag along and be as much help to them as they
19 can to keep them involved, but not expect the medical school to
20 run the thing.

21 I think the additional funding will help because it
22 shows that we're not turning our back on them. They have the
23 potentialities. The medical society would like to run a
24 successful show and I would hope that they will give better
25 cooperation than they did in appointing Dick McKenzie.

1 DR. HUNT: Are you talking about the Pennsylvania
2 Medical Society or the county society?
3 DR. MARGULIES: The Pennsylvania Medical Society.
4 DR. HUNT: I would recommend that you get the
5 Pennsylvania Medical Society out of this and put the Dauphin
6 Medical Society into this. On the one hand you're dealing with
7 administrative officers who have a statewide obligation and
8 also an elective board of trustees that have a statewide obli-
9 gation and are not knowledgeable or primarily concerned with the
10 Susquehanna Valley, but I think that possibly another sponsoring
11 group, like the Dauphin Country Medical Society and the
12 surrounding groups possibly -- and I second what Russell has
13 said about the medical school. You talk about leadership --
14 I think that that's where the leadership has to change, too.
15 DR. ROTH: I wouldn't go along with that. I wouldn't
16 change that.
17 DR. HUNT: You can't start a medical school with
18 these kinds of statements out in the community.
19 DR. SCHREINER: I was up there just recently and in
20 Hershey there is no physician problem. All of the people did
21 exactly what he asked them to do. They are all working there,
22 with one exception that left town.
23 DR. HUNT: The other thing I think that influences
24 this, Harold, is that this is an area that is probably the most
25 evenly affluent community in all the country. It really is.

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1 There's practically no indigent population in this area.

2 DR. CANNON: I was on the site visit team survey for
3 Susquehanna Valley and I'd like to give you some of the
4 impressions which cut across what you have said and some of
5 what Russ said.

6 Number one, I don't think that they have a real big
7 problem outside of the one of having the proper coordinator.
8 They have got a good young staff. The staff at Susquehanna
9 I thought was one of the best staffs, and Dick McKenzie put it
10 completely together but what he didn't have, he couldn't sit
11 eyeball to eyeball with the physicians. You see they looked
12 down on him. The dean looked down on him. In fact, the dean
13 was so disinterested during our meeting there that he didn't
14 say a word, even when we tried to get him to enter into the
15 discussion he failed to do so.

16 I see nothing wrong with the Pennsylvania Medical
17 Society being the grantee. It's not the elected board of
18 trustees. They have a separate committee, a sort of foundation,
19 that is supposed to run the RMP affairs, but they perhaps
20 haven't used good judgment in failing to replace the coordinator
21 which was put there by the state executive. So I really don't
22 think you have any problem in Susquehanna Valley other than
23 getting a good, strong coordinator with a medical background
24 that can talk straight to doctors on an equal basis. I think
25 the school would be asking RMP for help then.

1 DR. MARGULIES: Fine. The one thing that I thought
2 that I would like to do in discussing their selection of a
3 new coordinator is to make sure that they do consult fully with
4 the Regional Advisory Group. There is no requirement that they
5 do so but I think that this would be a balancing device
6 considering the fact that there is so much accusation in that
7 area and I continue to get telephone calls claiming that the
8 medical society is trying to run things the way they always
9 have. I had the same impression you did, Bland, when they came
10 down here to talk about it. I think they recognized the need
11 to do things differently. I think the medical society really
12 wants to have a good RMP. It's no joy for them to take on this
13 one particular activity as a statewide medical society, but I
14 think they do recognize their responsibilities and want to get
15 the job done.
16 So if they can select a good coordinator, I would be
17 inclined to say that they have done the best thing to move into
18 a position --
19 DR. CANNON: They have a man there that's on a part-
20 time basis.--I think he's a cardiologist -- during the meeting
21 of today days I would have picked as being an excellent
22 coordinator, and I told them in front of the group and
23 McKenzie that he's the one that ought to be coordinator, so
24 it's in the minutes. They know the story. I have been
25 receiving phone calls too.

1 DR. MARGULIES: I think both of these that we have
2 discussed represent some progress reports and I think they sort
3 of set the stage for what we have to talk about in a moment. I
4 would also like to mention to you since we last met that there
5 have been some other coordinator changes. Fitz has resigned
6 from New Mexico and he's been replaced by Jim Gay, whom you
7 know I'm sure, Bland, a neurosurgeon. We won't hold that
8 against him. We'll assume he can do well anyway.
9 DR. CANNON: He's an organizational man.
10 DR. ROTH: Can he survive the fact that he was a
11 classmate of mine?
12 DR. MARGULIES: I haven't tested him on that one,
13 either.
14 DR. DE BAKEY: Is Fitz staying out there?
15 DR. SCHREINER: No.
16 DR. KOMAROFF: He's thinking of spending a year with
17 the Commonwealth.
18 DR. MARGULIES: That's my understanding. There's a
19 new coordinator in Nebraska. Morgan has resigned and has been
20 replaced. Al Heustis has retired and they are in search of
21 a new coordinator at Michigan. This was retirement because it
22 was a time in his life when he wanted to retire. There was no
23 particular issue involved in that one.
24 Are there others that you recall at the moment?

25 MR. PETERSON: I think the Greater Delaware Valley

1 one has been known for some time.

2 DR. MARGULIS: We talked about that. There is a

3 replacement in the coordinator in the Greater Delaware Valley

4 on an interim basis. They haven't selected a new one.

5 Now, let me just bring up -- and I don't think we can

6 get very far with this discussion this afternoon -- some of

7 the problems which you will see, and this is in anticipation

8 of the review of the New York programs because it was impossible

9 for us to further escape the issues which are involved in those

10 programs and it was a rather extraordinary exercise during the

11 review committee which was more hysterical than historical so

12 far as I was concerned; that they went to the program in

13 Rochester and Albany and the one in Syracuse and independently

14 each of these review committees recommended that somebody be

15 found as an assistant coordinator to bolster up the existing

16 coordinator so he can somehow function in an effective fashion,

17 and it seems to me apparent as I sat listening to them that what

18 they really were talking about is fire these guys and get some-

19 b ody who's good.

20 Well, that appears to be a more complicated device

21 in the flow of events than it needs to be because that really

22 is the problem in each of these cases. The rather extraordinary

23 situation in New York in which you once set up on a regional

24 basis would appear to be very sensible arrangements around the

25 medical schools, and some of them with most remarkable resources

1 like Rochester, which should be an ideal place for regionaliza-
2 tion of medical care -- and with the exception of RMP tends to
3 be that kind of an area -- and I think it has never happened
4 there any more than it has in Albany or in Syracuse.

5 The review committee was very reluctant -- in fact,
6 they refused to make any comment for your benefit on what needs
7 to be done about New York, but they were deeply troubled by
8 the fact that you had one good RMP in Buffalo and the rest quite
9 inadequate. In the rest of New York you're dealing with down-
10 state New York and with a variety of circumstances and apparentl
11 no natural mechanism, no political mechanism, no social
12 mechanism in the State of New York to bring these groups
13 together the way one might have been able to do as we did in
14 Ohio. At least there was enough commonality to begin to talk
15 to them about it.

16 Now, the only kind of encouragement I have had was
17 an opportunity I took to speak with Dr. Mou, who is Vice
18 Chancellor of Medical Affairs at SUNY, State University of New
19 York system, and I raised with him the possibility of creating
20 a kind of coordinating environment in the State of New York
21 through their educational process which has an amazing strength.
22 You know, the SUNY system has something like 350,000 students
23 in it and at the present time is, by far, the largest source of
24 health manpower, excepting physicians, for the State.

25 The poor guy had to go to a meeting with 32 deans of

1 nursing schools, and a fellow who can do that and come through
2 is capable of some some very remarkable things.
3 They have set up in the SUNY system a kind of
4 advisory steering committee which has on it such people as Ed
5 Pelligrino and the new dean of Downstate, who, interestingly
6 enough, is Plimpton, who has resigned his position at Amherst
7 to go down there to get back in the medical education end of
8 things.
9 I have suggested that we would be very willing to
10 talk with that group about the health care systems and the
11 educational potentialities in the State of New York. We might
12 be able to get a total view of what needs to be done by that
13 kind of a route, but SUNY is involved with only some of the
14 medical schools which have RMPs and is not involved with others.
15 The CHP agency is not well-designed in the State of New York
16 for that purpose and we don't have any pivotal point upon which
17 to bring these together.
18 So I think we will have to seek some other kind of
19 political method to move into the area and if any of you have
20 some wise thoughts on it they would be most welcome, because
21 it's going to have great difficulty in surviving. I don't think
22 anybody seriously believes that we can solve the problems of
23 metropolitan New York versus the rest of New York with or
24 without RMP, so I'm not proposing that. But you will find, as
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25 you get to the review of these programs, that it's a tough one

1 and it isn't simply a matter of leadership in that case but a
2 matter of separatism and the lack of territorial interest.
3 DR. DE BAKEY: But, Harold, there has to be some kind
4 of certain ingredients in a place like Rochester. Now, they
5 have great strength in their medical school. They have great
6 strength in their surrounding community. The practitioners in
7 that area are certainly a good group, and you can't help but
8 feel that there must be some factor or some ingredient that is
9 missing in not being able to develop the concept of a good
10 RMP program in that area.
11 DR. EVERIST: Well, they have been project oriented
12 the whole time and their projects have been pedestrian, and
13 that's one of the major reasons they haven't done anything.
14 DR. DE BAKEY: But, you know, I can understand that
15 they have been project oriented and I agree with you that many
16 of their projects are certainly lacking in any innovative
17 aspects, but it seems to me like it's more than that. I get the
18 distinct impression in discussions we have had previously
19 about them and the reviews we have had previously of their
20 projects and so on that it's kind of being used -- not really
21 being developed for the purposes of the goals and objectives
22 of the RMP, but rather being used for sort of isolated purposes
23 within the area, that somehow the concept has been missed and
24 it's been used by both the practitioners and the university
25 group by simple projects which in a sense isolate the activity

1 for that sort of isolated purpose.

2 Again, I can't help but feel that it must be related

3 to a lack of leadership in giving them the concept and a lack

4 of the RAG group in understanding the concept.

5 DR. MARGULIS: Well, I think you're right. In each

6 case we have the interesting phenomenon of a coordinator who's

7 a very nice guy, and it always comes out the same way. "He's

8 such a nice fellow and he's served us so well in past years that

9 what can you do about it?"

10 I guess all I'm saying at this point is that I

11 suspect that there is a way of getting at this problem which is

12 not the same as the Ohio one but which I'd like to have you

13 bear in mind tomorrow as we go through the review process

14 because it's a common kind of an issue.

15 DR. EVERIST: It looks as if that one is a natural

16 for the California type of solution.

17 DR. MARGULIES: It could be.

18 Now, one other thing that I want to mention that we

19 have brought up in the past having to do with this whole

20 territorial problem. You may remember that the State of

21 Nevada was keenly interested in being separate as a Regional

22 Medical Program. I think that the intensity of interest in

23 going in that direction has been ameliorated somewhat, but the

24 issue has not disappeared.

25 One of the things which I believe they recognized in

1 the process of trying to become separate is that the funding
2 circumstances didn't suggest that there was any great advantage
3 to them in thus doing so, so that is less of a problem.
4 The State of Delaware is something totally different
5 and the State of Delaware is determined that it will be a
6 Regional Medical Program separate from Greater Delaware Valley,
7 which does not leave us unencumbered with other kinds of
8 problems, and they have pushed very hard through the governor
9 for the creation of a new arrangement with a separate RMP with
10 some strong concepts about comprehensive health planning being
11 developed to a higher level and with a new kind of state
12 government which has a Department of Human Resources and which
13 really does know what it's about. They argue that there is no
14 way in the world in which the State of Delaware can get the
15 attention from the city of Philadelphia and that's rather hard
16 to argue against.
17 They have a combination of health manpower people,
18 facilities people, welfare groups and so forth, who are working
19 well together, and have a clear idea when they come to us of
20 what they are after.
21 What is now under discussion, and we are going to be
22 having some meetings with them very soon, is the possibility of
23 doing something which the Secretary and the Administrator of
24 HSMHA are interested in, and that is using a small state like
25 that as a place in which one can test the possibilities of

1 combining state and federal health activities in some sort of
2 quasi-governmental structure which would include an input from
3 the Regional Medical Programs to make some sense out of their
4 health care system in what is really an area not very large
5 territorially and not very large in population. Most of its
6 major territory area resources are outside of the area, like
7 in Philadelphia or in Baltimore or even in New York.
8 So the discussion is moving in that direction. It's
9 becoming a bigger kind of an issue than just RMP and is really
10 becoming an expression of interest in HEW in finding other more
11 sensible ways of dealing with state governments and with their
12 health activities.
13 This still leaves us, however, no matter how it comes
14 out, with the problems of the relationships between Delaware and
15 Philadelphia and the Greater Delaware Valley and all that that
16 implies, not the least of which is the very keen interest of
17 Chairman Flood, and I think that has to be borne in mind. In
18 fact, I bear it in mind regularly.
19 So I think that we haven't resolved that one either,
20 but the push is there. The governor is concerned and he's not
21 backing away from it. He knows what he's after and I think that
22 we are likely to see some kind of very specific proposal come
23 in from there. What we did tell them is that there is no
24 reason why they and the State of Delaware cannot initiate on

25 their own an effort to create a separate RMP, set up the

1 organizational structure and bring it to the Council for its
2 consideration, and they plan to do this.
3 DR. CANNON: Have you heard anything from New Jersey?
4 DR. MARGULIES: No. We have left them out of con-
5 sideration for the moment also.
6 DR. EVERIST: I think that would be a great idea, for
7 RMP to pick up and take a leadership role in the business of
8 this experimental plan with a state the size of Delaware.
9 DR. MARGULIES: I think it has very good possibilities.
10 If you look at the State of Delaware, it's also a rather ideal
11 place for an area health education center in Wilmington. It's
12 got all the potentialities. They have got a strong Veterans
13 Administration hospital activity there and it was one of the
14 places selected in the Carnegie Commission Report -- and
15 certainly not the place for a medical school, with all the
16 medical schools right across the border in Philadelphia -- but
17 they have a sense of integrity as a state which they want to
18 stick with.
19 Now, it's fairly late, so I'm not going to go beyond
20 this point, excepting to suggest to you that a lot of the dis-
21 cussion we have been having in the last few minutes has been
22 raising issues of regional distribution and raising questions
23 of state boundaries, and we have from time to time been asked
24 to reconsider -- and I'm sure it's going to happen in the
25 future, and the future may not be too distant -- the whole issue

1 of what sort of division of regions we're talking about in the
2 RMP. I will share with you in the very near future a paper
3 which we prepared, primarily with Pete's input, on the issues
4 which would be involved in considering state boundaries for
5 RMPs rather than the original concept. I can see Bland
6 flinching already, but, nevertheless, if you look at all the
7 issues on the way they're presently distributed and ask yourself,
8 well, where does RMP work well and where does it work poorly and
9 are the original issues the same as they are now and what is
10 happening to the political system in terms of state boundaries;
11 how will it be affected by new concepts of federal/state
12 relationships and so forth; it's something which is not going to
13 disappear. It's going to get closer and closer to some kind
14 of resolution and we are not ready for it now but we have to
15 think about it.

16 You know, Bland, we only have really two areas which
17 represent the kind of problem that Memphis is, and that's
18 Memphis and St. Louis. When you start looking over the other
19 parts of the country, they are virtually all state boundaries
20 or several programs within a state or multiples of states. We
21 can make exceptions, but I think that there's a lot of pressure
22 to move in that direction.

23 DR. CANNON: You're not going to -- well, we don't
24 want to get into that argument now, but when you start shaking
25 up the natural trend of referral patterns and geographic units

1 that have been set up in this country either by natural rivers
2 or highways or whatever, the culture of an area to make it fit
3 into the political boundaries of states, I think you're going to
4 get this program into trouble, Harold.
5 DR. MARGULIES: I always like to hear a guy from the
6 South speak against states' rights.
7 DR. CANNON: I know, but I can see it will ruin the
8 regional program.
9 DR. MARGULIES: I think this is a very good point
10 upon which to adjourn the meeting today. I would like to
11 adjourn on a happier note because I just received a letter today
12 which is the kind I like to see occasionally. This is
13 addressed to Paul Ward from Carl Smith, who is the Acting
14 Director of CHP in California.
15 (Reading letter)
16 DR. DE BAKEY: Harold, only one other thing. Is
17 there any way you can find out -- I understood the Senate/House
18 Conference Committee was meeting today.
19 DR. MARGULIES: On the appropriations?
20 DR. DE BAKEY: Yes.
21 DR. MARGULIES: I think we can find out about it.
22 DR. DE BAKEY: It would be nice to know because of
23 all the talk we have heard here. You know, one thing you've
24 got to keep in mind is that unless we get the money it doesn't
25 do any good.

DR. MARGULIES: Yes, I know about that.

Thank you.

(Whereupon, the Executive Session adjourned at 4:25 p.m.)