Kansas Legislative Research Department | September 16, 1976

M I N U T E S

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

July 14 and 15, 1976

Members Present

Senator W. H. Sowers, Chairman
Representative Richard B. Walker, Vice-Chairman
Senator Bert Chaney
Senator Elwaine F. Pomeroy
Representative Arthur Douville
Representative Sharon Hess
Representative Michael G. Johnson
Representative Marvin L. Littlejohn

Staff Present

Emalene Correll, Kansas Legislative Research Department
William G. Wolff, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes Office
Sherman Parks, Jr., Revisor of Statutes Office

Others Present

Kent Culbertson, Phillipsburg, Kansas
McDill Boyd, Phillipsburg, Kansas
Doug Johnson, Kansas Pharmaceutical Association, Topeka, Kansas
Lloyd Hall, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Ruth Dickinson, Division of Planning and Research, Topeka, Kansas
Gary Caruther, Kansas Medical Society, Topeka, Kansas
Carl Schmitthenner, Kansas State Dental Association, Topeka, Kansas
E. Gail Harkness, Kansas Legislative Research Department, Topeka, Kansas
Ruth Groves, American Association of University Women of Kansas, Topeka, Kansas
Terry Whelan, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Pauline Bork, Department of Health and Environment, Topeka, Kansas
Paul E. Fleener, Kansas Farm Bureau, Manhattan, Kansas
Jerry Slaughter, Kansas Medical Society, Topeka, Kansas
Richard L. Burnett, Kansas State Dental Association, Topeka, Kansas
Edward C. Staley, Kansas State Dental Association, Topeka, Kansas
Dr. C. E. Petterson, M.D., Syracuse, Kansas
Dr. Emerson Yoder, M.D., Denton, Kansas
Elizabeth Carlson, Board of Healing Arts, Topeka, Kansas
Dr. James E. Hill, M.D., Board of Healing Arts, Arkansas City, Kansas
Edgerton Taylor, Ombudsman, Department of Social and Rehabilitation Services, Topeka, Kansas
Dick Brown, Kansas Health Care Association, Topeka
William E. Richards, Department of Social and Rehabilitation Services, Topeka, Kansas
Jan T. Walker, University of Kansas Medical Center, Kansas City, Kansas
Representative Keith Farrar, Hugoton, Kansas
Dr. Robert Kugel, University of Kansas Medical Center, Kansas City, Kansas
Robert W. Brown, University of Kansas Medical Center, Kansas City, Kansas
Marlin Rein, Kansas Legislative Research Department, Topeka, Kansas
Dr. Jesse Rising, University of Kansas Medical Center, Kansas City, Kansas
Dr. Dwight J. Mulford, M.D., Dean of Admission,s Kansas University Medical Center, Kansas City, Kansas
Verner O. Nellsch, Student, KUMC, Havana, Kansas
Dan Suiter, M.D., Chief House Officer, KUMC, Shawnee, Kansas
David Waxman, M.D., KUMC, Kansas City, Kansas
Jack Walker, M.D., KUMC, Kansas City, Kansas

July 14, 1976

Morning Session

The meeting was called to order at 10:15 a.m. by the Chairman. The first item for consideration was a statement on Proposal No. 32 - Adult Care Homes.

Proposal No. 32 - Adult Care Homes

Edgerton Taylor, Adult Care Home Ombudsman, presented a written statement and attachments (Attachment A).

In response to questions, Mr. Taylor stated that all complaints are investigated to determine their validity: of the 40 investigations to date, about 35 or 36 were found to be valid. Most complaints involve medical services (primarily nursing care) and food. The high turnover of personnel, which is approximately 50 percent per year, is the major contributing factor in medical service complaints. Mr. Taylor noted that there is a two to three month backlog in investigating complaints because there is only one staff member and because a substantial amount of time is required to investigate some complaints.

Asked for his recommendations, Mr. Taylor recommended increased wages and fringe benefits as a means to reduce personnel turnover in adult care homes. In response to a question relating to the increased cost of these recommendations, Mr. Taylor suggested looking at the financial records of adult care homes before the Department of Social and Rehabilitation Services allows an increase in payments.

In response to a question about the goal of providing ombudsman services to at least 1,000 nursing home patients by July, 1977, Mr. Taylor referred to the local ombudsman program outlined in Attachment A. He clarified his statement to indicate that services were to be available to 1,000 patients rather than to find 1,000 complaints. Persons with background in law or hospital or nursing home care are being sought as local ombudsmen.

Reference was made to testimony given before the Senate Public Health and Welfare Committee indicating that state institutions are moving mentally retarded and mentally ill persons into adult care homes not adequately staffed to meet their needs. Mr. Taylor stated he had received two complaints in this area which are presently being investigated.

Proposal No. 33 - Medically Underserved Areas

The Chairman reviewed Proposal No. 33 and asked that conferees assist the Committee in defining "underserved."

Archie Dykes, Chancellor, University of Kansas, introduced staff from the University of Kansas School of Medicine. He noted that "underserved" is a relative term but should include the criteria of how difficult it is to see a physician. For example, using this criteria, Topeka is medically underserved by primary care physicians.

Chancellor Dykes presented a written statement (Attachment B).

Robert Kugel, M.D., Executive Vice-Chancellor, University of Kansas School of Medicine, noted that meeting the needs of medically underserved areas is a problem of distribution which affects both urban and rural areas.

Dr. Kugel noted that Kansans have a tendency to underplay what we have to offer. Medical students are being actively recruited by communities outside Kansas. There is a need to show students that Kansas is a good place to practice and that Kansas communities are interested in them and where they choose to practice.

Dr. Kugel elaborated on some of the programs summarized in Dr. Dyke's statement and noted that some entering students had an opportunity to spend one week with a practitioner outside the Kansas City area prior to starting medical school. The

University is working with the Kansas Medical Society to enlarge this program in order that all entering students will have an opportunity to participate.

The Executive Vice-Chancellor stated that he and some of his colleagues are visiting Kansas communities, primarily small communities in western Kansas, to develop an understanding of community concerns. This program has been well received. Dr. Kugel stressed that it is important for everyone -- the school, the medical profession, the community and the Legislature -- to work together to solve the problem of medically underserved areas.

Dr. Kugel conveyed the feeling among physicians that solo practice is "as dead as the dodo bird." For this reason, the School of Medicine is encouraging communities to recruit at least two physicians. Communities which have followed this practice have been more successful in recruiting, but it is a difficult point to get local groups to understand. Those who are involved in recruiting doctors also fail to involve the student's family, particularly the wife who may cast the deciding vote about place of practice.

In answer to questions about practice in small communities, Dr. Kugel stated that statistical data shows that life expentancy is ten years less for a doctor in a small town.

Dr. Kugel responded to a question about the definition of primary care physicians by stating that primary care includes family practice, internal medicine, obstetrics and gynecology, and pediatrics. There is no generally accepted agreement on the definition of primary care although HEW uses the above categories. Primary care is considered to be care given to a patient up to the point of referral. On this basis, many general surgeons are also primary care providers.

The School of Medicine is attempting to increase the number of graduates in primary care specialities through development of the Department of Family Practice and through increasing the number of primary care residencies. The goal is to have 50 percent of graduates in primary care residencies. A problem in meeting this goal is a shortage of first-year residency positions in Kansas. Increasing residencies is important because the location of a student's residency is a major determining factor in where he practices. Statistics show that about 50 percent of the K.U. graduates who take their residency in Kansas remain in Kansas. Only about 30 percent of those who go elsewhere for a residency return to Kansas. This ratio seems to hold true for other states also.

Reference was made to the last "Bulletin" of the medical school which summarized where graduates are taking residencies. Dr. Kugel stated there are about 45 serving in primary care residencies in Kansas City and, he thought, about 30 in Wichita.

Responding to a question, Dr. Kugel stated that providing for residency training is increasingly becoming a legislative responsibility because hospitals are strapped for money and feel they cannot continue to provide residency positions. According to an HEW study, the actual cost to a hospital of maintaining a resident is about twice the stipend paid to the resident. At the University of Kansas Medical Center, house officers (postgraduate students) are paid $11,000 the first year with a step increase each year. This is below the national average: the national range is from $8,000 to $19,000.

Dr. Kugel stated that the biggest problem in reaching a goal of 50 percent of graduates in primary care residencies is budget. Seventy-five first year residency positions are available in Kansas now. This gap will be closed by the addition of 12 new positions next year through the integrated family practice program. Thirteen positions are needed to reach the goal of 100.

Dr. Kugel was asked if he is requesting state support for enough positions to meet the goal of 100 residency positions. He responded that his August 13 budget presentation would include a plan to increase the 12 positions approved by the 1976 Legislature to 16. The goal is to reach 100 positions by 1980. He further noted the gap of 25 residencies includes those in private hospitals in Wichita over which the University has no control.

Asked why he did not ask for enough positions to reach the 1980 goal now, Dr. Kugel replied that the question gave him food for thought. He also noted that one

problem with providing new first-year positions is that there is no guarantee of second and third year funding. For example, there is now state funding for 12 new first-year positions but no assurance of funding for the second and third years.

Asked how many students in the last graduating class were seeking residencies in primary care, Dr. Kugel indicated that he was not sure but he believed 35 to 40 percent of the last class were in primary care specialities. Dr. Kugel will forward this information to the Committee.

There was discussion of requirements for accredited residencies and it was brought out that a portion of postgraduate training must take place in a hospital setting. While the University is trying to include experience in a doctor's office for residents, it should not be assumed that all postgraduate training can be outside of a hospital setting. In general, a 200-bed hospital is the minimum size which can provide a varied enough patient population for students.

The Chairman noted that the Committee staff had tried to get current data on where physicians are practicing and on their practice speciality but had been unable to find current data. Dr. Kugel was asked what data should be compiled if the Legislature were to mandate that data collection take place. This information is currently being developed for all K.U. graduates and should be available by September 1. There was agreement that the best way to maintain data on physician location and practice would be to tie it to the license renewal procedure. In response to a question, Dr. Kugel indicated it would be practical for the School of Medicine and the Board of Healing Arts to get together to develop the type of data which should be collected.

Dr. Kugel, in answer to a question, stated the objective of the Outreach Task Force, which reports to him, as bringing increased awareness of community problems and concerns to the faculty and students. The Task Force also makes communities more aware of the role of the School of Medicine.

Dr. Kugel replied to a question about the feasibility of service-tied loans, by stating that such loans are useful when there is also a "pay-back" provision. Such loans are one way for the state to show it is really interested in the student and the place he chooses to practice. There will not be a "huge" return from such loans, but they are among a number of things which should be done to encourage doctors to practice in Kansas communities.

After a recess for lunch, the Committee reconvened to hear Dr. Cramer Reed, M.D., Vice-Chancellor, University of Kansas School of Medicine, Wichita Branch. Dr. Reed's statement and recommendations are included in the minutes as Attachment C.

In response to questions from the Committee, Dr. Reed stated that new physicians are being "tuned in" to the use of physician extenders during their training. Integrated education provides for communication between these groups. Dr. Reed also expanded on his statements about needing to define the roles of physician extenders through rules and regulations.

Responding to further questions, Dr. Reed stated that there are problems with a PA (physicians assistant) seeing patients in the hospital. Physicians are on hospital boards and influence decisions relating to the PA. The litigation experience has been good and the malpractice insurance rate of the physician using a PA is very low; however, hospital administrators and boards are concerned about their liability.

Dr. Reed referred to the health care provider survey made through the Regional Medical Program, noting that the survey had been computerized to make up-dating feasible. Funding is no longer available through RMP but the data base is still available. The Chancellor stated that the University is undertaking to administer a data base which will provide the location of all K.U. graduates. This data base could be expanded to include all Kansas health care providers.

The next conferee, Jesse Rising, M.D., Department of Continuing Education, University of Kansas School of Medicine, gave his opinions on why doctors practice where they do. His experience includes private practice, over 20 years of involvement in the preceptorship program, travel over the state visiting with doctors, and 23 years of association with continuing education in health care.

Dr. Rising expressed the opinion that where a doctor practices depends on what the doctor and his wife perceive the community has to offer. They are not seeking

isolation -- professional, cultural, educational or recreational. Money is at the bottom of the list. They want a decent life, a chance to raise and educate a family, and a chance to keep up with medicine. Dr. Rising emphasized the need to have colleagues to talk with.

Dr. Rising stated that students are looking for a practice with a peer not an opportunity to work under an older doctor. Places which have been successful in getting younger doctors are those where young men have recruited young men. Physician recruitment needs to be actively carried out by someone seeking a partner, not an assistant. This sometimes is not the case with older physicians. Dr. Rising suggested that a doctor looks at the availability of facilities -- an office and a laboratory and hospital within a reasonable distance -- as well as the availability of consultants. at least within telephone contact.

In answer to questions, Dr. Rising outlined an ideal practice group that he had formulated as one he would like to join: several family physicians, one general internist, one general pediatrician, one general OB-GYN, a clinical psychiatrist or psychologist and as many physician extenders as physicians. He noted that the group at Norton is close to this pattern. He suggested that west of Highway 81, a practice group in a small town could serve a very wide area.

Jack Walker, M.D., Chairman of the Department of Family Practice, University of Kansas School of Medicine, was the fourth conferee on Proposal No. 33. He explained that the family practice specialty is the old general physician with a new name and more training. A family practitioner is willing to accept the responsibility for continuing care of all members of a family. He can care for about 80 percent of the family's medical problems and knows where to go for assistance with the other 20 percent.

Dr. Walker outlined the history of events which led to the present shortage of family physicians and the creation of the American Board of Family Medicine. He explained that there are now 260 residency programs in family practice. Two are in Kansas -- Kansas City and Wichita. The medical school program started with three residents in Kansas City in 1972, and in 1976 there are twenty-four. Seventy-six residencies in family medicine are now available, with twenty-seven of them first-year positions. While this may seem to be a small number, it is a great step forward from six years ago when there was not a family medicine residency in the country. There are now about 4,000 persons training to be family doctors and ten to twelve new programs are being added each year.

Dr. Walker stated that family practice students are trained on a broad base by using faculty from other specialties to help in training and by rotating students through the specialties and sub-specialties. The Department of Family Practice uses the resources of the Medical Center, Wichita and doctor's offices. Each student spends two months in a small community with a family practice group.

Dr. Walker noted the need for more resident positions in family practice, pointing out that such positions are not tied to the Medical School so that applicants can be from other areas. Last year there were 100 applicants for 8 positions. Of the 100 applicants, 60 were applicants who were considered. Wichita had about the same ratio of applicants to positions. In the integrated family practice concept, about one-half the additional resident positions authorized by the 1976 Legislature will start in Kansas City and half in Wichita. In the last two years the resident will move into out-lying areas. It was noted that this program is costly because there will be 12 positions the first year, 24 the second year, and 36 the third year. The annual budget for the Department is in excess of $500,000; $100,000 is federal money which is being phased out and $100,000 is from fees.

Dr. Dan Suiter, Chief Resident and President of the Residents Association, noted residents, those in the first three years after medical school, are caught in a dichotomy. They are salaried by the state and in the eyes of the state they are employed but in the eyes of the IRS they are not. Residents feel they are employees of the state but feel the state does not really view them this way. Two things have happened in the last year. The medical malpractice controversy has reached the house staff officer. The contract says the resident's malpractice insurance will be paid. However, some residents are now being asked to pay the $200 per year cost. Previously a resident and his family had gratus medical care. Those entering now have to obtain their own health insurance. Both factors have struck this year and do not make it attractive to take a residency in Kansas.

Dr. Suiter stated he graduated from K.U. in 1967 and from K.U. Medical School in 1971. After serving a one-year internship at the University of Arkansas, he had to fulfill his military obligation by spending two years in Montana as a flight surgeon. He stated that when he left Montana to return to a residency at K.U., he had a strong feeling for the Northwest. If his residency had been completed before he went in service, he probably would have set up a practice in the Northwest where he had friends and roots.

Dr. Suiter referred to the discussion about expanding the residency program and noted the need to also look at what this might do to the medical education of the residents. Increasing the ratio of residents to staff could affect the quality of the resident's education and training. Spending time away from K.U. or the Wichita Branch has already met with resistance by house staff. House staff feels they need full-time salaried professors to obtain the education they need.

In answer to a question, Dr. Suiter stated he had been approached by some Kansas communities partly at his initiative. He has spent one month in Halstead and he comes from western Kansas. In 1971, as a senior in medical school, he was approached by groups wanting to fill internships. Groups from other states came to town with a lot of money and got a number of students.

Dr. Suiter, in answer to a question, stated that he and his wife come from Stafford County and there is a pull to stay close to family. However, size and future of the community is important in choosing a place to practice. It is foolish to ask a man in his thirties to come to a town that is decreasing in size. He stated he grew up on a farm and these are the type of people he is comfortable with. He noted, however, that he is concerned about cultural shock even though he comes from a small community. Dr. Suiter stated that availability of other health care providers is probably the number one thing to consider in location of a practice. He noted he had received an attractive offer for a practice when he came out of the Air Force but turned it down because of the isolation. He stated he plans, at this time, to return to western Kansas, but is not completely sure that is what he will do.

Dr. Dwight J. Mulford, Dean of Admissions, K.U. School of Medicine, distributed five exhibits pertaining to admissions (Attachment D). He stated that 223 Kansans are enrolled in medical school, 22 of whom are enrolled in out-of-state schools. In answer to a question, Dr. Mulford explained that when a student fills out an application, he is asked what his home county is. If he is attending school in a county other than his "home" county, he may list the county where he is attending school.

Dr. Mulford emphasized the importance of recruitment, noting it needs to be started at the high school level. There needs to be a real recruitment from counties that do not have any applicants.

Dr. Robert Brown, Director, Regional Medical Program, gave a brief background of the development and thrust of the Regional Medical Program, noting the program will go out of existence in September. RMP has processed over 150 grant applications and funded about 100 projects during the last 10 years.

Data analysis was one project of the program staff. Such analysis indicated rural areas bear the brunt of the maldistribution of medical services. They also noted a steady flow of specialists into medium size communities -- communities of less than 20,000 -- who are having trouble making it. Dr. Brown noted that the supply of services will never keep up with the demand for health services because the demand is inexhaustible. At some point a decision has to be made about how much health care a person is entitled to receive if a third party is going to pay for it. People need access to services but perhaps not in an unlimited fashion.

Dr. Brown reviewed various of the RMP projects, noting they had a project to develop a 12-county area health education center in Great Bend to include recruitment for faculty, a rotation program for residents, and an educational program for health care providers. The hospital and medical staff went through an agonizing year working through problems and qualifying for an outreach program. However, the program never became operational because of changes at the medical center at Great Bend and the fact the staff did not want to take on a project of this magnitude. Dr. Brown noted setting up a full-time teaching program in a small hospital is difficult and time consuming.

The Regional Medical Program also helped develop outreach personnel. From a questionnaire sent to all doctors in 1961, they found 60 percent were opposed to nurse clinicians, 20 percent said they would participate in a nurse clinicial program and 20 percent said they did not care. There was some, but very little, criticism of this program from physicians and nurses but none from patients. RMP did not try to identify every task the nurse clinician could do. He noted that if this route is taken, there would be no nurse clinicians or physicians assistants. In RMP, nurse clinicians were given maximum latitude and the results are now being assessed. As soon as this report is finished, a copy will be forwarded to the Committee.

Dr. Brown reviewed a brief experiment with an outreach program between a Dodge City medical group and nurse clinicians based in Cimarron. While that project closed down because Cimarron recruited a doctor, similar projects need to be tried. Dr. Brown also mentioned the Indian mobile health service, noting this concept has some possible use in association with a strong central program.

Verner Nellsch, a second year medical student, stated he came from a small Kansas community, Havana, Kansas. He suggested that a medical student has to be approached by a community before making a specialty decision. An opportunity must be provided to expose students to a small town. The neediest towns should come to the medical schools and meet the students. The student can then choose the towns he would like to visit on a recruitment weekend. He could see the town, talk to the people and get a small appreciation of what small town life is like. Mr. Nellsch also suggested recruiting residents who already want to go to a small town.

A student, Mr. Nellsch stated, wants to know the size of a community, the number of practicing doctors in the area, and the condition of the schools. He emphasized that a student does not want to get stuck somewhere alone. They see too many doctors from small towns coming in on the autopsy table.

Mr. Nellsch referred to a study "Boys in White," by Becker and Geer published in 1961. The study, done at KUMC, shows the factors students listed as most important to them in choosing a field of medicine:

"33% - Intellectual challenge and learning opportunity.
24% - Attractiveness of the subject matter or the aims of the specialty.
18% - Certainty of benefits to patients.
16% - Comprehensiveness of the specialty.
10% - Preference for caring for that type patient."

He noted the three highest factors are found in family practice. He noted that one-third of his class are student members of the family practice organization.

Mr. Nellsch stated he wanted to get across that students are interested in family practice but not quite enough to make a commitment to it. Students will not actively hunt out a small town but they are interested. Small towns would benefit by more active recruitment. He also suggested that once contacts are made they should be kept up. In answer to a question, Mr. Nellsch stated that when he used the term "small town," he thought of a town of about 3,000.

Dr. Brown stated there is too much competition between towns to sell themselves at the expense of another town when they both need a doctor. A doctor is a regional resource. Community education needs to be approached on the basis of a regional concept. Recruitment on the basis of an area, rather than a single town, might bear more fruit.

The Chairman thanked all of those who had appeared before the Committee. The meeting was adjourned at 6:15 p.m.

July 15, 1976

McDill Boyd, Phillipsburg, presented a written statement (Attachment E).

Mr. Boyd reviewed the experience of Phillips County noting they provided all the facilities to practice good medicine. There is training for nurse clinicians; free plane service for emergencies; qualified people available to help the doctor in various ways; training support for three nurses a year and the Hanson Foundation has helped improve the quality of life in the community. But they could not get a doctor, partly because there were none capable of moving into a rural community as a general physician.

Through the Hanson Foundation they are financing young people in medical school. Eight completed residencies this year. Two of these came back to northwest Kansas; two went to work for $60,000 per year. He stated that two out of eight may seem a small proportion but it is a life-saving thing for the area. The two decided to come back because of personal relationships established with people in the community during their education. One will complete his training in 1977 and another in 1978. Both say they will practice in northwest Kansas. Mr. Boyd stated the Foundation grant is for $4,000 per year and repayment is waived on return to the area. Originally, grants were offered to people from their area accepted in a three-year program. However, this year policy changes were made and applicants now must have completed one year to apply.

In answer to a question, Mr. Boyd stated he felt grants are a good approach. However, he stated he feels the personal contact from people in the community had as much importance as the grant. He visited the students personally and took them to dinner when he was in Kansas City. Some people in the community wrote to them. The grant opened the door because without it, they would not have met these students, but personal contacts after this were important.

It was suggested that residencies or a part of the residency might be served in underserved areas. Mr. Boyd stated that if this approach is adopted, it would add a year to the residency but Kansas would be getting more return for its money.

In answer to questions and comments, Mr. Boyd stated that if family practice programs are to be increased and are to be effective, attitudes must be changed and curricula reassignments made. There should be a class for family practice students in each department. He felt attitudes and lack of a great enough internal effort to accommodate the family practice student were factors limiting the growth of the program. He stated he thought Dr. Kugel was committed to changing this.

Paul Fleener, Director of Public Affairs, Kansas Farm Bureau, presented a written statement (Attachment F). He stated that Mary Wiersma, a member of their staff, serves on a medical outreach committee and some of the problems spoken to by the Farm Bureau delegates in their policy statement are being addressed by these committees.

Mr. Fleener stated he had served as a layman on the selection committee at the Medical School this year. When the committee looked at grades, some high recommendations of the interview committees were thrown out. Some with high grade qualifications were not admitted because of responses brought out by the interview teams.

In answer to a series of questions, Mr. Fleener stated that this year some students were accepted at the Medical School with a lower grade point average than those not admitted. They were accepted on their ability to relate to people, their warmth and what appeared to be their capability of responding to a person as a whole being. However, their grade points were still high. Mr. Fleener reviewed the selection process for the Committee.

In answer to a question, Mr. Fleener stated he did not think the faculty at the Medical School was doing all they could to enlarge the number of family practitioners available. He felt Dr. Cooper, who had served on the interview team with him, is also enlisting support from others. The new Executive Vice-Chancellor is attempting to focus on this problem and come to grips with it. Attempts are being made to overcome the inward look at the Medical Center and among medical people.

Lloyd Hall, Executive Director, Kansas Association of Osteopathic Medicine, presented a written statement. (Attachment G) He noted that in the course of education in osteopathic colleges a student is rotated through all departments and is put into a rather extensive exposure to clinical practice in clinical settings in the college and in communities. In excess of 100 students are in the preceptorship program in Kansas which

is also being expanded. At the end of a student's five years of training, he is ready to go into general practice and is highly qualified.

Mr. Hall stated the Governor had vetoed their request for a program to assist colleges of osteopathic medicine which accept Kansas students for valid reasons relating to procedural questions. However, some type of program needs to be developed if schools are to continue taking Kansas students. The college at Kirksville is talking about an outreach program in which students would spend two years at Kirksville and two years at a hospital in the state from which they came. They are looking for a state willing to be the pilot for this program. He stated the Wichita Osteopathic Hospital has been approved for an internship program and has six interns now.

Mr. Hall stated they have brought about 40 doctors to Kansas in the last four years. About one-half of these are in rural communities. They have worked with the Hanson Foundation to get doctors in western Kansas. Their own foundation funded seven students, two of whom were from Kansas and returned to Kansas. None of the others came to Kansas. For this reason they would rather work with Kansas students. They have expanded the hospital in Wichita and have put together a clinic with six general practitioners, one pediatrician, one surgeon and one OB-GYN surgeon. They are looking for an intern in the clinic now.

In answer to a question, Mr. Hall stated their recommendation is that the state provide funds to the osteopathic school and to the student on a pay-back basis. They feel at least 34 percent of Kansas students come back to Kansas.

Mr. Hall, in answer to questions, stated DO's can be board certified in specialties. Most postgraduate programs are three years, although most students spend more time than that before starting to practice in a specialty. In 1969 the AMA recommended to their specialty boards that they recognize the osteopathic boards or put osteopathic students through their own boards and most of them do. Also some of the osteopathic graduates go into a residency in a medical hospital. Several have gone through Menninger's training program.

In answer to a question, Mr. Hall stated the State of Kansas does not have to pay for osteopathic students. But there is a practical situation which has to be faced. The school in Missouri has been willing to cooperate, but this year saw a decline in the number of Kansas students accepted. If there are too many problems implementing the recommended program a better solution would be to build a school in Kansas. In answer to a question about building and operating cost for a school initially for 100 students, Mr. Hall stated HEW would fund part of any facility built. It would take about $8,000,000 to $10,000,000 to build clinical facilities for the basic sciences. In addition, space for clinical training would be needed although it might be better to use out-of-state facilities not committed to other schools. He stated he did not know what operational costs would be but he would get figures from some of the colleges.

In answer to a question, Mr. Hall stated loan programs help but how successful they are in increasing the number of permanent practitioners in Kansas depends on how the program is administered. For example, whether it is done through the Board of Regents or by a foundation; whether or not the administering body keeps in touch with the student receiving the loan.

Carl Schmitthenner, Executive Director, Kansas Dental Society, presented a written statement (Attachment H). In answer to questions, Mr. Schmitthenner clarified the following points: they have some concern about problems which could arise if HEW guidelines and programs are followed. They are not sure a dentist could support a practice in Stanton County with a population of 2,530 for instance. HEW obviously did not use its own criteria when designating certain Kansas communities as underserved. They are asking HEW to correct this. A certain number of slots in the dental schools at Kansas City and Creighton are purchased each year by the state.

Edward C. Staley, DDS, a salaried dentist from the National Health Service Corps assigned to Mound City and special advisor to the Committee on Manpower of the Kansas State Dental Association, stated a community has to raise quite a bit of money to have a dentist placed by the Corps. In answer to an earlier question, he stated a community has two options to acquire dental equipment: (1) they can purchase the equipment themselves, or (2) they can purchase a GSA dental package which is paid back on a graduated basis from funds the dentist assigned makes in his practice.

The rest of Dr. Staley's remarks were given in answer to questions from the Committee and staff.

Dr. Staley stated he was recruited by the National Health Service Corps while he was in school. He was given a choice of three places. Pressure was so great he took the position in Mound City before he saw the community. He is the only full-time practicing dentist in a county of 8,374. A dentist from Olathe spends about one-half his time in the community. In some respects the community is underserved and in some it is not. Generally speaking, with the population's level of dental education they could get along with a dental surgeon. Some people continue to go to Ft. Scott which has about five dentists for a population of 9,000 or to Butler, Missouri, which has three full-time dentists. Dr. Staley felt the community could get by with a half-time dentist. Whether this area should take precedence over other areas depends partly on definitions and he felt he was not familiar enough with other areas to make a judgement.

It would be economically feasible for a dentist to practice in this community. However, because of criteria he had set for himself, it might not be economically feasible for him.

Dr. Staley stated one of his goals has been to see if a private practice in a small rural community was feasible. He is not sure he will stay in Kansas but he will practice in a rural community because he likes the life.

Dr. Staley noted that about one-third of his patients are medicaid patients who take up about one-half his time. This point is an important consideration for a person going into private practice because payment is on a percentile basis rather than full payment.

Richard Bennett, DDS, Chairman, Council on Dental Education and Manpower, Kansas State Dental Association presented a written statement (Attachment J).

In answer to a question, Dr. Bennett stated some dentists, orthodontists and oral surgeons have outreach offices in towns other than the one in which they have their primary practice.

Jerry Slaughter, Executive Director, Kansas Medical Society, introduced the president, Dr. Emerson Yoder, who stated he practices in the smallest community in Kansas which has a doctor. Dr. Yoder noted defining underserved is difficult and he could not list definite criteria to use. In Kansas the ratio is 1 doctor to 1,000 population. The area west of Highway 80 accounts for about 60 percent of the area of the state but for only about 40 percent of the population. The assumption has been that the problem of inadequate health services and facilities is limited to this section of the state. Dr. Yoder stated he hoped people do not keep laboring under this assumption. It is also a problem in the eastern part of the state and in cities. He mentioned an area in the eastern part of the state with an 85-bed hospital now served by four doctors, three of whom are in their 70's. When these three retire, the community will lose the remaining doctor who is in his 40's.

Speaking of facilities, Dr. Yoder noted it is better to drive an extra 10 or 20 miles than to have a hospital closer which is not properly equipped or properly staffed.

Dr. Yoder stated some people are concerned that KUMC is training people to go out of state to practice. He noted that in Sedgwick County, 48 percent of the doctors came from KUMC and 62 percent from other places. He feels this has made a better medical community than if they all came from KUMC. He stated he did not think filling the total need in Kansas with Kansas trained doctors would be an optimum situation. Migration to and from the state is good because you get input from other schools and other places.

Dr. Yoder stated he did not think subsidizing doctors or forcing them to go into given areas was an optimal solution if satisfactory health services are to be provided. Buying a doctor and putting him in a town will not do it. He noted these are his views and not necessarily those of the Kansas Medical Society.

Dr. Yoder listed the following as important in attracting a doctor to a community: at least two doctors; availability of facilities; the way the community reacts to him and treats him. Things which are important to a doctor are: whether he likes the community; can be make a living there; are labs, hospitals and consultation easily available; is there someplace to refer his patients if needed. There is a need to look at what doctors want and then try to match that.

James Hill, M.D., Secretary, Kansas State Board of Healing Arts, distributed information relative to the number of MD's and DO's licensed in the state, the number practicing in the state, and other information. He noted many of the inquiries from out-of-state MD's or DO's about being licensed in Kansas come from Kansas City because they really need both licenses to practice. He noted that if an out-of-state doctor just sees a patient a few times or in his own office, he does not need a Kansas license.

The difficulty of getting information about the location and essential characteristics which are needed to help evaluate the level of health care was noted. Dr. Hill was asked if it would be practical to require the Department of Health and Environment, with the help of the Board of Healing Arts, to collect such information and keep it current. Dr. Hill stated this could be done through a re-registration each year. They do not now collect or maintain this information for doctors. Neither do they ascertain whether a doctor is practicing full-time, part-time or is retired. The Board could collect this information if it is desirable.

In answer to a question, Dr. Hill stated they ask doctors to notify them if they move but they are not required to do so by statute or by rules and regulations. He did not see any problem in requiring practitioners to notify the Board within 30 days when they change their place of practice.

Cecil Petterson, MD, Ulysses, emphasized his agreement with the statement that if a community wants a doctor they will have to recruit two, not one. Dr. Petterson stated he practices in a town of 2,000. The county population is about 3,000 but there are about 6,000 in the outlying areas which include some of Colorado. He noted the problems of having to know and understand state policies (in his case, for two states), welfare regulations and medicare and medicaid programs. He stated he had not been in favor of physicians assistants until a friend called saying he was looking for a place for a PA serving a preceptorship with him. The PA agreed to work for a few months without pay to show what he could do. In three weeks, Dr. Petterson said, he was convinced he could not do without him.

He noted the problem being looked at is one of getting doctors in a community. However, another fact which must be faced is the trouble people have getting into the health care system. Not enough emphasis is placed on personal characteristics of patients and their needs. People do not know how to get in to see a doctor. A paramedical around the doctor that they can get to or who can get to them is a help. Sometimes they just need someone to listen. If a community gets a doctor, they also need ancillary personnel he can depend on.

In answer to a question, Dr. Petterson said his PA has been well accepted in the community. He has had training in obstetrics and pediatrics. He stated that the PA has brought new things from the well baby clinic to him. The young people in town have empathy with this young man.

Dr. Petterson distributed copies of his contract with his PA.

Dr. Petterson was asked what would happen to his PA if he left his practice. Could he work in the hospital? Dr. Petterson said this is something which needs to be looked at. He noted the problem of getting hospital administrators and suggested a PA might be able to move into this type position. He also stated he felt a PA can serve two doctors but he did not feel a doctor should have more than one PA. It is too difficult to supervise more than one PA.

<u>Minutes</u>

In discussion of the minutes of the June meeting, staff noted that Attachment A was not attached to the minutes because a copy was not yet available. The Chairman asked that references to attached material on page 3 be clarified before action is taken on the minutes.

The meeting was adjourned.

Prepared by Emalene Correll

Approved by Committee on:

9/21/76
Date

Attachment E

STATEMENT BEFORE

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

July 15, 1976

I want to congratulate this committee for taking a hard look at the delivery of health care in Kansas. It is a complex, a difficult, a confusing subject. And I expect to speak bluntly from a layman's standpoint.

My conclusions are based upon a study completed by the Kansas Regional Medical Program in August 1974, updated, and rechecked in February, 1975; and a summary which appeared in the Kansas Medical Society Journal in February, 1976.

These figures are not pulled out of a hat. They are very real. They indicate a major disaster, close at hand, in many communities in our state. Complete copies are herewith made available to this committee.

As a preface, let me say that Kansas is not alone in this dilemna. For 25 years, medical teaching schools all across the country have concentrated upon research and the pursuit of excellence in the various specialties, almost to the virtual exclusion of physicians capable of treating the whole person.

Medical journals everywhere are literally filled with ads for physicians, but they want family physicians, doctors who can take care of the sick at the community level; doctors who have been trained to treat mumps, measles and the bellyache, to bind our wounds, deliver our babies, meet the needs of the elderly, provide a first point of reference when illness strikes, and refer to specialists, that 10% of their patients who need specialty services.

Medical schools have not been producing this kind of doctor. They have provided specialists who can utilize new discoveries to performs modern miracles in medicine, but 90% of the public need lies in another direction. Taking care of people where they get sick and when they get sick -- providing doctors to meet the ordinary ills of ordinary folks -- must have top priority.

And suddenly, the medical profession has recognized this void. The AMA now recommends that 50% of all medical students be directed into primary care, with special imphasis on family practice. Such departments have been springing up all across the country (there were none at all in 1970) but the need is so great across the nation, that Kansas cannot expect an in-migration. As a matter of cold fact, unless trends are reversed, Kansas will continue to lose doctors.

For the past 20 years, 64% of all graduates at the K.U. Medical Center have left the state to practice medicine after Kansas has paid for their education. And doctors are retiring, dying, or changing location in Kansas faster than new doctors are coming onto the scene.

Since the bulk of the attrition among older physicians occurs in general or family practice, a desperate situation is rapidly growing worse.

Using figures in the February 1976 issue of the Journal of the Kansas Medical Society, Kansas has a total deficit of 790 physicians, with a shortage of 613 in primary care alone. Nearly 80% of the shortage is in this one category alone.

Yet of 453 advanced students, only 36 are in family practice; 72 in internal medicine and 18 in pediatrics -- a total of 126 in all three primary care categories. The need calls for 80% in primary care in Kansas, yet only 28% of our advanced students are trending in that direction.

Since three year residencies are required, 42 advanced students will complete their work each year in the primary care field, and if all remained in Kansas, it would take 15 years to meet the verified needs of 1980, only 4 years hence. If Kansas continues to retain only one of every three graduates, the new physicians now on their way through advanced training will not even meet the rate of attrition, and the shortage will get worse instead of better.

I realize that we are now hearing the 51% of our students are in primary care -- but no curriculum changes of consequence have been made since the study was completed. The truth is that OB-GYN and general surgery have somehow been included in primary care -- but only the name has been changed.

I submit to you that an advanced student in OB-GYN, or a surgery specialist with three, four or five years of advanced training in his field, has no intention of becoming a family doctor in a community setting.

And what would communities of modest size do with a pathologist who couldn't bind a finger; an anesthesiologist who wouldn't recognize ringworm; a cardiologist confronted with a broken bone; or a radiologist with a sick baby on his hands?

There is no way to touch upon all aspects of this problem, but if we are to have physicians who can look after people who get sick, where they get sick and when they get sick, we cannot afford to confine medical education to narrow channels.

I hereby refer to one of the charts compiled in the February, 1975 report by the Kansas Regional Medical Program: "Estimated 1980 Physician Needs in Kansas":

Under the column "excesses or deficits" 507 general and family practice physicians will be needed in only four years. 218 will be needed in internal medicine and 104 in pediatrics ... a total of 829 in the traditional primary care field. The total needed in <u>all</u> other categories is only 317. We already have enough advanced students on the way to meet that goal. The tragedy of insufficient health care for people is in the primary care field.

What can the legislature do? How can this problem be approached? There are two suggestions which make sense for the immediate future.

It is time to take a look at the residency program, and to put taxpayers money to work to meet the needs of the public.

Referring to an accompanying chart: "Kansas House Staff Training Needs Related to Projects, 1980", we find that we already have more house staff in training at some point in their residencies, and in some categories, than we will need four years hence.

Kansas is now paying advanced medical students stipends of up to $12,000 annually to stay in school after they have been qualified as physicians. They are certified at the end of the first year of residency, or internship, and then stay on to pursue specialities and sub-specialties whether Kansas needs them or not.

In only two categories do we face a shortfall by 1980 -- family practice and OB-GYN. We have more students in advanced training in <u>all</u> other fields than we will need four years hence. The ratio is particularly distressing in pathology, radiology, anesthesiology and psychiatry.

Kansas is inevitably educating these young people for export. Their services will not be needed here when they complete their work.

I do not suggest cutting back on residency funding. This would be short-sighted indeed, but I do suggest that the legislature could ear-mark the use of residency funds for the advanced training of young physicians in those fields needed <u>in Kansas</u> for the improved delivery of health care.

Those fields have been clearly defined by careful study. I realize that some department heads will literally "go through the roof" if such a change is brought about. They are distinguished in their own fields. They attempt to build programs which will rival Johns Hopkins or some other distinguished medical school. They will seek to maintain this distinguished flavor, for the urge of men to reproduce in their own image is as old as mankind.

But when the taxpayers" money -- and the health of the people of the state -- are at stake, stern measures are necessary.

We have been told that 51% of our medical students are in primary care. I would like to see at least 50% of residency funding ear-marked for those categories, with one major proviso:

Not more than 50% of residency allotments in any department would be spent to sustain sub-specialty residents. I repeat: Once a student enters a sub-specialty, the chances that he will practice medicine in a community setting is remote indeed.

Instead, I would suggest that more family practice residents be given more exposure within the various departments. That's where our distinguished medical leadership lies within University teaching walls.

We should want our fledgling physicians to have the best possible guidance.

Let me give you an example: When a family practice student is assigned to surgery, he becomes a fifth wheel. He never holds a scalpel in his hand. Senior surgical residents, preoccupied with difficult operations, are so far ahead of the family practice student that he cannot even comprehend the nature of the work. I suggest that classes of student -- in their first year of residency -- be taught beginning surgery. They would then be exposed to distinguished surgeons, and working on problems within their scope.

The same thing should be true in OB-GYN, where family practice students do not deliver babies -- they only watch. And if all medical students should be exposed to the distinguished leadership in the psychiatry department, in classes designed for that purpose, at least they would be able to recognize the symptoms of mental distress when they begin the practice of medicine in communities around the state, and refer patients properly when the need is first recognized.

The out-reach program which has been started, is fine, but the hazards are extreme. Accreditation is hard to come by. Instead of shipping family practice residents into out-lying hospitals for their work, the number of residents in other specialties and sub-specialties could be reduced to conform to Kansas need, and family practice residents would gain the advantage of a learning experience under the distinguished teaching talent available within the departments at the K.U. Medical Center.

There is a second alternative worthy of consideration:

After medical students have completed their academic work and one year of advanced study (internship) they are qualified as physicians.

The next year of training could then be spent in general hospital situations around the state, learning to care for the whole person. They would then be free to enter a specialty or sub-specialty work at the Medical Center.

With 200 medical students annually, one-fourth this number, or 50 young physicians, would then serve Kansas for at least one year, and even if they left the state after the completion of their residencies, the people of the state would have had some value from the money expended for their education.

And it is the opinion of many specialists that young physicians should have some experience with the whole person <u>before</u> concentrating in one narrow field of service where physicians learn practically everything about one aspect of medicine, and hardly anything at all about the rest.

Kansas has taken some forward steps in trying to cope with the emergency which exists in the delivery of health care, but no program will work without physicians at the heart of it, and few communities

in Kansas can sustain the cadre of specialists necessary to cover all the ills of all the people.

It takes family physicians to do that; and I now refer to the study of doctor location in Kansas to illsutrate the drastic need for just this kind of doctors. More than one and one-quarter million people in our state are now far below the national norm, where doctors are forced to take care fo the ills of more than 4,000 people in many areas, and I refer you to the material herewith submitted for detailed data.

The big, new facility costing some $60 million is fine. The increase in the number of enetering students is wonderful. The change in emphasis toward primary care is "just what the doctor ordered" in Kansas. The attempts to interest students in family practice through longer preceptorships and pre-rotation are steps in the right direction.

But unless the legislature ear-marks appropriations for residencies, and mandates the expenditure of money for the education of the kind of doctors Kansas needs, all the rest will not put physicians into Kansas communities (big cities, small cities and rural areas alike) where they are so desperately needed.

Specialty medical education should be maintained at the K.U. Medical Center, and not dispersed. That's where the facilities and the distinguished leadership in all fields are available. No new programs should be authorized unless they are needed to serve the people of Kansas. Medical students should be channeled into the disciplines which will serve Kansas best.

And the only avenue available to the Legislature to accomplish these ofjectives is through the mandated control of appropriations.

McDill "Huck" Boyd