Kansas Legislative Research Department July 28, 1977

M I N U T E S

SPECIAL COMMITTEE ON WAYS AND MEANS - A

July 6 and 7, 1977

Chairman Wint Winter called the Ways and Means - A interim committee meeting to order at 9:30 a.m. on July 6, 1977, at the University of Kansas Medical Center. Committee members attending, in addition to Senator Winter, were: Representative R.E. Arbuthnot, Representative Mike Hayden, Representative Rex Hoy, Representative Ruth Luzzati, Representative Irving Niles, and Representative George Wingert. Staff members present were Emalene Correll, Robert Epps, Norman Furse, and Marlin Rein.

Proposal No. 69 - Retention of Medical School Graduates in Kansas

Chancellor Archie Dykes welcomed members of the Committee to the University of Kansas Medical Center then generally reviewed programs of the Medical Center to increase the number of physicians in Kansas. Chancellor Dykes pointed out that the enrollment of the Medical School's freshman class had been increased from 125 in 1970 to 200 in 1975. Efforts to improve the admissions process at the Medical Center have included the addition of several lay citizens to the admissions committee. Special efforts have also been made to admit students from rural areas of the state based on the assumption that they would be more likely to return to the rural areas to practice medicine. It was also explained that the expanded medical preceptorship program was working well. Under this program medical students spend part of their training working with physicians in rural areas of the state such as Harper and Greensburg. Chancellor Dykes then called upon Dr. Robert Kugel to comment upon Kansas Health Day and Rural Health Weekend programs.

Dr. Kugel explained that the Kansas Health Day and Rural Health Weekend programs served to heighten the awareness of students of opportunities in rural areas. These programs introduced students to an area of medical practice that was previously overlooked in the training program.

Dr. Joe Meek explained the new Affiliated Family Practice Program which establishes linkages between the Medical Center and local communities. Under this program students will spend the first year at the Medical Center and the second and third years at an affiliate location. Dr. Meek noted that currently Garden City and Salina have shown the most interest in this program. However, efforts are being made to develop similar programs in Topeka and Pittsburg.

Dr. Jack Walker commented that there are numerous problems in developing such programs. For example, the Medical Center must gain approval from both the Family Practice Review Board and the Liaison Committee for Graduate Education in the United States.

Representative Hayden inquired about the status of Hutchinson in the Affiliated Family Practice Program since it was designated in last year's bill. Dr. Meek replied that Hutchinson was somewhat hesitant to enter into such a program at the present time. Mr. Rein then inquired about the impact of the reduction in the number of beds at the Garden City Hospital on the Affiliated Family Practice Program. Dr. Meek replied that the number of beds required in this program is 200; however, Garden City now has only 150 beds. It is possible, however, to count some of the beds at the Medical Center for the first year with the program.

Dr. David Waxman was called upon to review the residency program for foreign medical graduates in the state. According to Dr. Waxman, the University of Kansas Medical Center has recently taken in four foreign medical graduates into its residency programs. Two are American citizens and two are citizens of Viet Nam. Dr. Waxman also noted that P.L. 84-484 requires the acceptance of foreign medical students into residency programs.

Representative Hayden inquired as to the capacity of the Medical Center for training foreign medical graduates. Dr. Waxman responded that it was difficult to evaluate the Medical Center's capacity for this kind of training. However, he estimated a maximum of six students per year.

Senator Winter then asked for a description of the so-called "fifth pathway concept." Dr. Waxman explained the "fifth pathway concept" is for medically trained individuals who do not have a medical degree. Such individuals would have completed complete medical training at a foreign medical school, such as the one at Guadalajara, but because of the institution's extensive service requirements, they do not actually have a Doctor of Medicine degree. Under the "fifth pathway concept" such students would be trained at the University of Kansas Medical Center to the extent that they are able to be licensed by the State Board of Healing Arts. Chancellor Dykes commented that such students are required to sign a document agreeing to stay in Kansas after the additional training period.

Senator Winter inquired as to who determined the obligation placed on foreign medical graduates. According to Dr. Waxman, the obligation is determined by faculty of the Medical Center. Senator Winter then asked if graduates of the "fifth pathway" program were able to practice medicine as though they had obtained a medical degree. According to Dr. Waxman, the "fifth pathway" participants are able to practice medicine and are eligible for membership in the AMA. It was noted, however, that the American Association of Medical Schools discourages the "fifth pathway" program. Dr. Kugel stressed that the AAMC could not unilaterally block the program. However, the Liaison Committee did have the power to stop the program.

Dr. Norton Greenburger explained other residencies located throughout the state. He noted that approximately 75 residents spend nearly 200 man-months at other locations throughout the state. The location of these residency positions include such communities as Garden City, Halstead, Hays, Kingman, Norton, Belleville, and Phillipsburg. Dr. Greenburger noted that some of the house staff were obligated to spend time in an outreach experience. In conducting the program, the Medical Center is making every attempt to be flexible in responding to where house staff residents want to gain outreach experience. According to Dr. Greenburger, this program should continue to grow. Mr. Rein inquired as to the number of the approximately 200 man-months spent in the Kansas City area. Dr. Greenburger responded that none of the 200 man-months were spent in the Kansas City area except for the surgery residencies at Shawnee Mission and Bethany Hospitals.

Dr. Joe Meek explained to the Committee that the staff of the Medical Center is attempting to develop a unified Kansas health plan addressed to the physician maldistribution in the state. It is anticipated that a physician recruitment and location office will be developed and located at the Medical Center. At this time, however, the precise duties and responsibilities of this office have not been developed. The Rural Health Institute in Chanute, Kansas was also discussed by Dr. Meek. According to Dr. Meek, this facility will use the resources of the Medical Center to address the health problems of Southeast Kansas. The resources of the rehabilitation institute will also be involved in this venture. According to Dr. Meek, the institute is a good example of the University of Kansas Medical Center helping a specific rural region of the state.

Representative Luzzati inquired about the admissions criteria of the institute. Dr. Redford responded by pointing out that the primary focus of the institute will be a rehabilitation program that prevents institutionalization.

Mr. Rein then asked who would operate the institute. Dr. Meek responded that operation will involve both the University and the community. Dr. Meek also pointed out a secondary purpose of the rural health institute will be to provide continuing education programs for health professionals in Southeast Kansas. A possible third purpose will be the initiation of a rural health laboratory. It was also indicated that both federal and private support from the Kellogg Institute are a possibility for funding the rural health lab. Dr. Kugel indicated that an additional purpose of the institute will be to conduct research into what attracts young people to a particular rural area.

Dr. Meek also discussed the locum tenums program of the Medical Center. He pointed out that the Medical Center is making efforts to get physicians out to county medical society meetings and local clinics. Representative Hayden inquired as to the number of man-days spent in the locum tenums program. Mr. Von Ende responded that an update of the report will be available in one week.

Representative Hayden also expressed concern about young residents charging excessively high fees in rural communities. It was suggested that the Medical Center set up guidelines to govern such fees. Dr. Meek responded by noting that fee guidelines have now been established by the Medical Center. Chancellor Dykes reiterated that the University was aware of this problem and is currently working to correct it.

Dr. Kugel commented on a new "physician-to-physician" program which consists of visits by Medical Center staff with rural area physicians. According to Dr. Kugel, this program is working well and considerable interest has been expressed by rural area physicians in the state.

Chairman Winter inquired about the state of research concerning care for the chronically medically disabled. According to Dr. Kugel, medical research in this area was lacking. Dr. Meek indicated that a framework of educational centers throughout the state would provide an anchor for a system of more general health care and would also serve as an aid in recruitment and retention of physicians in rural areas. Dr. Greensburg commented that he felt an airplane would be of considerable help in making the physician-to-physician program work better.

Mr. Walt Gehlbach reviewed generally the admissions process at the University of Kansas School of Medicine covering such aspects as goals of the admissions process, qualifications of applicants and the various phases of the selection process itself. He noted that in many instances the admissions process starts in junior high and early high school levels. Mr. Gehlbach pointed out that two aspects of the admissions process included an early admissions procedure for highly qualified students who are notified by October 1 of the year prior to their first year of medical school, and a second program aimed at identifying rural applicants.

In response to Representative Hayden's question about the early acceptance criteria, Mr. Gehlbach indicated that criteria is based on the combination of test scores and overall grade point average and science course grade averages. If all of these combined scores equal 1,000 or above, early admission is accepted. According to Dr. Waxman, the early admissions procedure is to get the very top students committed to the University of Kansas Medical School. Representative Hayden inquired as to why humanistic values were not applied to early admissions program. Mr. Gehlbach responded that the sole purpose of this early admissions process is to obligate the top academic performers to the Medical School to admission at the Medical School. Dr. Waxman added that the early admissions process tries to capture the top academic performers early in the overall admissions process. Representative Hayden expressed concern that the selection criteria for students in the early admissions process do not meet the overall purposes for practicing medicine in Kansas. Dr. Waxman responded that at this point no one really knows the qualities that make a "good" physician. Dr. Greenburg indicated that the application of humanistic values was more involved in the selection of health staff residents. This selection of course occurs at the end of medical school training just prior to residency.

Representative Luzzati inquired about the involvement of minority members on the admission panel. According to Mr. Gehlbach, both minorities and females are included on the admissions panels. Approximately 24 percent of the Medical School applicants are female and a corresponding percentage of admissions are female. According to Dr. Krantz, discrimination in the Medical School admissions process has all but ended.

Senator Winter asked who interviews the early admissions group. According to Mr. Gehlbach, a subcommittee of the admissions panel conducts this interview.

Representative Niles inquired as to what percentage of those who were not admitted to the University of Kansas Medical School receive admission to other schools. Mr. Gehlbach responded that less than ten percent of those denied admission at the University of Kansas are admitted to other medical schools. It was also pointed out that approximately ten percent of each year's applicants are re-applicants and that approximately 30 percent of the re-applicants are admitted.

The matter of retention of medical school graduates and residents was discussed by Mr. Von Ende who handed out a tabulation of where recent graduates were practicing. (A copy of this material is attached.) According to Mr. Von Ende, the area of residency training appears to be the strongest factor in predicting the location of a physician's practice.

Dr. Greenburg commented that with approximately 300 physicians trained at the Medical Center since 1974, 50 were still in training, 100 were practicing in Kansas, 30 were practicing in Kansas City, Missouri, 20 were currently employed by the United States government, 10 were deceased, and 15 were medical school faculty members and 75 were practicing elsewhere. According to this information, the retention rate of medical school graduates is approximately 40 percent.

Representative Luzzati requested comment on the new radiation therapy program. According to Dr. Waxman, a split has taken place in the radiology discipline, resulting in the creation of two separate disciplines of diagnosis and therapy.

Senator Winter inquired as to whether there was any suggestion that the Liaison Committee for Graduate Medical Education determines the number of trainees in a specific medical discipline based on need.

Dr. Greenburg replied that many factors are considered in determining the number of trainees in each of the medical disciplines. Senator Winter then asked whether a limiting factor is based on need in a particular discipline. Dr. Greenburg replied that various disciplines are in an early phase of making judgment on self limitations. For example, oncology and cardiology are working in this area at the present time. Dr. Waxman responded to this question by indicating that the federal Department of Health, Education, and Welfare may get involved in the determination of the number of residency positions in each discipline. Dr. Krantz explained that the number of patients in each category is a factor used in determining the number of residency positions.

At 12:05 p.m. Chairman Winter adjourned the Committee meeting for lunch.

The Committee then reconvened at 1:30 p.m. The physician recruitment program at the Medical Center was discussed by Mr. Von Ende. According to Mr. Von Ende, the University has applied to the Ozark Regional Commission for federal funding to add to the $34,000 appropriation for physician recruitment. If federal funding is approved, a total of approximately $75,000 would be available for the physician recruitment program. It is anticipated that the communities of Hays, Chanute, Wichita, and Dodge City would serve as physician recruitment centers.

Remarks provided by Mr. Joe Harkins of the Department of Health and Environment on the matter of physician recruitment in Kansas indicated that the national supply problem of physicians has been essentially solved in terms of absolute numbers because of the increased production of physicians by medical schools. The major problem for Kansas is obtaining a greater portion of the national supply of physicians and a more equitable distribution, particularly in rural areas of the state. According to Mr. Harkins, a problem of maldistribution can be resolved without legislative remedies at this time. In considering the distribution of health services, other professionals such as nurse practitioners and physician assistants should also be considered.

The initiation of a new nurse practitioner program at the Medical Center and at Hays should further alleviate the health manpower shortage in the near future. According to Mr. Harkins, the physician maldistribution problem can be resolved on a voluntary basis within a five-year period provided that physicians throughout the state, especially in rural areas, join efforts in recruiting other physicians.

Representative Luzzati inquired as to where the physician placement and recruitment offices would be located. Mr. Von Ende replied that these offices would be physically located in the district offices of the Department of Health and Environment. Mr. Rein asked about the involvement of other health professionals. Mr. Von Ende replied that these regional offices would be concerned with other allied health personnel. Mr. Rein then asked how this program would interface with the Wichita Branch program. Mr. Von Ende indicated that the involvement of the Wichita Branch in this program would be part of a rural effort coordinated by Dr. Meek. Mr. Rein also asked about the efforts of private physicians in this area. Mr. Von Ende indicated that the Kansas Medical Society has been involved in the planning phase of this program. Mr. Harkins reiterated that the individual physicians are a key element in the overall recruitment efforts in the state.

Representative Hayden expressed concern about small communities that are unwilling to cooperate in the recruitment effort. Mr. Harkins replied that recruitment and placement efforts must be geared to the various regional areas of the state rather than individual communities.

Dr. Joe McFarland of the Board of Regents' Office discussed the status of the osteopathic aid program. Dr. McFarland explained that a letter explaining the program was sent to a number of osteopathic colleges throughout the country. Only the Kansas City College of Osteopathy responded. However, only 15 Kansas freshman students were admitted for this fall while 25 were admitted a year ago. Several options were explained with regard to implementing the osteopathic aid program. One option would be to implement the aid program fully. The second option would provide for the implementation of a loan program only. A third option involves the implementation of the program for

upper level (i.e., junior and senior) positions only while holding the freshman portion until the fall of 1978. The fourth option would provide for payments to the college for freshman students under the basic bill. However, the school would remit to the state any funds received from state and the student in excess of the tuition. This would approximate $2,150 per student.

Senator Winter inquired as to whether the Board of Regents had the option to implement only portions of the aid program. Norman Furse responded that the Board of Regents does have the option to implement partially the provisions of the Osteopathic Aid Bill and that the law contains no strict requirement for full implementation. Representative Hayden expressed favor for the fourth option presented by Dr. McFarland. Representative Hayden moved that the Committee recommend this option under two conditions:

1. That at least 25 student slots be guaranteed for the next academic year; and

2. That the college guarantee to increase the number of student slots for Kansas residents if additional funding is provided.

The vote on this motion carried with four yes votes, two no votes, and one abstention. Senator Winter was recorded as voting no.

Dr. McFarland then handed out material which described the selection criteria as proposed by the Board of Regents. Senator Winter inquired about the definition of "Kansas Resident" as used in the selection criteria. Dr. McFarland explained that the term refers to one's legal residency status. Representative Hayden commented that a study by the University of Missouri indicated that students do not establish medical practices in communities smaller than those where they resided prior to medical school. It was suggested that such criteria should be used in the selection process. Senator Winter then cautioned Dr. McFarland to have the proposed selection criteria reviewed by counsel.

The Mediserve program was explained by Ms. Mary Wiersma of the Kansas Farm Bureau. Ms. Wiersma explained that the Mediserve program is based on a similar program in Illinois that has operated successfully since 1948. The program is a cooperative project of the Kansas Farm Bureau and the Kansas Medical Society and is based on the concept that certain students, by virtue of their rural background and experience, are particularly suited for practice in rural areas of the state.

The program offers three basic types of assistance:

1. Assistance with admission to medical school;

2. Financial assistance up to $750 per semester with a $6,000 maximum limit; and

3. Assistance in providing medical practitioners for rural and underserved areas of Kansas.

(A detailed description of the Mediserve program has been attached to these minutes.)

Ms. Wiersma explained that thus far this year the Mediserve has had nine contacts for admissions assistance and four contacts for financial assistance. Representative Hayden inquired about the weight of the Mediserve program's recommendation at the University of Kansas Medical Center. Ms. Wiersma quoted a letter from Chancellor Dykes indicating that 20 slots in the fall, 1977, class would be held for rural Kansans. Ms. Wiersma indicated that Mediserve required a one-year service obligation for each year of financial aid with a five-year maximum.

Representative Hayden inquired about the Mediserve program practices in Illinois when medical tuitions are increased. Ms. Wiersma explained that the Illinois Mediserve program had made no changes in the amount of loans since 1948.

Representative Hoy asked about the success in Illinois with regard to locating physicians in medically underserved areas. Ms. Wiersma explained that the overall success rate in Illinois has been between 80 and 96 percent.

At this point in the meeting Mr. Von Ende directed the Committee's attention to a comparison of medical school admissions in Kansas by congressional district. The following table reflects these admissions data:

TABLE I

Congressional Districts	1975	1977
1	26	48
2	36	40
3	62	59
4	50	37
5	14	23
TOTALS	188	207

Source: Mr. Richard Von Ende's compilation of data of medical schools for this specific Committee meeting.

Senator Winter asked how the State of Kansas compares with other states in medical school tuition rates. Chancellor Dykes responded by noting that the current Kansas medical tuition rate would appear in the upper median of state medical school tuition rates. The Kansas tuition rate is higher than that of Illinois. Mr. Rein noted that the State of Tennessee passed a bill similar to Senate Bill No. 447 during the last session and that the Governor vetoed this bill.

At this point Representative Hayden indicated the desire to explore several concepts relating to medical education:

I. The relationship between medical school tuition and costs. Concern was expressed that the University develop tuition rates based on the actual cost of various academic programs. Chairman Winter commented that physicians generally have much higher earning power and therefore should appropriately pay a higher tuition rate.

With regard to the "buy-out" provisions of Senate Bill No. 447, Dr. Krueger indicated that a high percentage of residents in the five-year psychiatry residency program "bought out" rather than spend a period of time serving in one of the state hospitals. Dr. Krueger then inquired whether the payback provisions in Senate Bill No. 447 were legal. Senator Winter indicated that the provisions were enforceable legally and that the bill also provides a moral obligation.

II. Citizens of Kansas have provided considerable support for medical education, yet the public has not received a fair return on its investment in terms of medical services in some areas of the state.

Dr. Walker responded that of the approximately 2,000 physicians currently practicing in Kansas approximately one-half are graduates of the University of Kansas School of Medicine, indicating an adequate return on the investment period. Dr. Walker also indicated a need for more primary care physicians in the state to go along with tertiary care medical providers.

Representative Hayden then commented that only four out of 105 counties in Kansas have an adequate care base, based on the "Florida Base Line" studies of one medical provider for every 650 citizens. Mr. Harkins of the Department of Health and Environment then commented that there have been no substantial changes since 1973 in the physician to public ratio in Kansas, indicating a low level of medical services in some counties.

III. What kinds of incentives are looked upon favorably in the attraction of physicians? Dr. Walker indicated that physicians generally have no quarrel with incentive programs for attracting physicians. Dr. Krueger indicated that one incentive would be the development of more group practices so that some degree of work relief could result. Dr. Kugel then noted that both Pittsburg and Colby are communities that have been highly successful in recruiting physicians.

IV. The voluntary aspects of House Bill No. 2264 were not apparent. Dr. Walker concurred that the provisions of this bill were perceived by many physicians as being involuntary.

Representative Wingert then inquired whether it would be possible to separate the Medical Center's budget into hospital and education functions. Mr. Von Ende responded to this question by pointing out that officials of the Medical Center are now currently working on the development of separate budgets for the hospital and educational programs.

Senator Winter adjourned the meeting at 4:50 p.m.

July 7, 1977

Senator Winter reconvened the meeting at 8:30 a.m. July 7, 1977. Additional Committee members in attendance included Representative Mike Glover and Senator Billy McCray.

Mr. Al Tikwart, mayor of Westwood Hills, Kansas, spoke generally about health care problems and the financing of medical education in Kansas. Mr. Tikwart termed the shortage of physicians in Kansas as being acute and indicated that the number of the University of Kansas Medical School graduates that leave the state has risen from 56 percent in 1975 to 64 percent in 1976 and an estimated 70 percent in 1977. He indicated that tuition should be raised to a minimum of $20,000 per year to offset tax-supported increases in the cost of medical education.

In response to a specific question concerning his views regarding medical education in Kansas, Mr. Tikwart recommended that the tuition rate be raised to actual cost and that three prioritized areas of need be established for medical service throughout the state. Mr. Tikwart also recommended increasing the number of physicians in Kansas, especially in the area of general practice. To help finance the costs of medical education, he suggested that an endowment program could be administered by the State Board of Regents under which physicians would pay back the school the costs of their education. As proposed, the endowment program would operate under guidelines set by the Kansas Legislature.

Mr. Tikwart also indicated that he liked the gradient system employed in House Bill No. 2264 and the repayment concept in Senate Bill Bo. 447. Representative Hayden commented that medical education legislation should address the problems of outmigration of physicians and maldistribution of physicians. He also indicated that specific geographic areas need to be indicated in legislation to correct the maldistribution problem. It was suggested that rural areas, cities, parts of cities, and state hospitals should be included as areas of need.

Dr. Walker commented that the basic law of supply and demand does not seem to work in medical services. He therefore supports Representative Hayden's proposal because of its incentives.

Mr. Rein remarked that both bills speak to the problem of retaining medical practitioners in Kansas. The distribution of medical services including support personnel and medical facilities should also be considered in regard to the retention problem.

Dr. Krueger then indicated that some medical specialties do not lend themselves to rural practice settings. Dr. Waxman expressed concern over an equal protection problem in the proposed legislation in that it would discriminate against new students. Senator Winter commented that the bill is in essence concerned with the equal treatment of citizens in Kansas.

Mrs. Campbell of Humbolt, Kansas commented that it is important for the Committee to distinguish between the needs as opposed to the wants of the public. For example, she indicated that many people in the Humboldt area whom she has surveyed have indicated that they would continue to obtain medical services in the Wichita area, even if more medical services were provided in the Humboldt area.

Representative Hoy inquired as to how long it would take more members of the Legislature to know whether the proposed programs were working. Representative Hayden replied that a minimum of four years and more likely, eight to ten years, would be required to determine the effectiveness of the programs.

Dr. Walker reminded the Committee that the University of Kansas Medical Center has acted recently on increasing both the number of physicians in Kansas and general practitioners. As yet, the Medical Center has not addressed the maldistribution problem of physicians but intends to do so.

Ms. Correll also reminded the Committee that the Legislature recently established a state health planning structure and that the first state health plan is due before the next session. Presumably this plan will include areas of need for medical services.

Senator Winter mentioned three areas that the Committee should consider during the interim, those being the subjects of medical costs, medical education, and physician extenders.

Representative Hayden then made a motion to request reports from the Medical Center prior to the October meeting for short-term solutions for the shortage and maldistribution problem of medical services and to provide a cost analysis of the program to train foreign medical school graduates on internship programs that conform to the rules of the State Board of Healing Arts. This motion was adopted unanimously.

Senator Winter then moved that a cost analysis of the "fifth pathway" program and information regarding the federal mandates on medical education also be provided prior to the October meeting. This motion was also unanimously adopted.

At this point the Committee turned its attention to the matter of the Rainbow Unit review.

Proposal No. 71 - Rainbow Mental Health Center

Mr. Robert Epps reviewed with the Committee the staff report which had been prepared providing historical data on the development of the Rainbow Mental Health Center together with current program information for the facility. Following the presentation of the staff report and a brief discussion the Committee adjourned to go to the Rainbow Mental Health Center.

After arriving at the Rainbow Mental Health Center, the Committee broke up into groups and with the assistance of staff of the Center, a tour was made of the facility. At 12:00 p.m. the group recessed for lunch.

The meeting reconvened at 1:00 p.m. in a staff conference room at the Rainbow Mental Health Center. The persons in attendance at this staff meeting are identified in an attachment to these minutes. Mr. Hal Boyts, Director of the Johnson County Mental Health Center, presented members of the Committee with a copy of a task force report on the Rainbow Mental Health Center which is identified in the attachments to these minutes. Mr. Boyts characterized the present problems of the Rainbow Unit as principally being the result of a scrambled administrative organization. He noted that many different groups have a piece of the administrative action and the employees are unclear as for whom they work. Mr. Boyts also noted that the Rainbow Unit had experienced problems with Osawatomie State Hospital and the Division of Institutional Management largely because the Rainbow Center has a community philosophy which does not necessarily match with state institutional and funding philosophies.

In response to questions concerning the use of the Rainbow Center by the Johnson County Mental Health Center, Mr. Boyts noted that the use of Rainbow has been minimal because the Johnson County Mental Health Center does utilize facilities in Mission Hospital for limited day care programming. In response to a question as to the

level of county funds which went into support of the Rainbow Mental Health Center, Mr. Boyts noted that the only funds furnished from Johnson County were federal staffing grant funds approximating $90,000.

In response to a Committee question concerning capacity of the Rainbow Mental Health Center and present utilization, Mr. Jack Southwick, Director of the Rainbow Center, indicated that capacity for partial hospitalization is approximately 100 for both adults and children and an inpatient capacity of approximately 59. He noted that inpatient census has averaged approximately 90 percent of capacity with partial hospitalization about 75 to 80 percent.

Mr. Southwick went on to note that Mr. Mills, superintendent of the Osawatomie State Hospital, is legally accountable for programming at Rainbow but does not have direct control. In turn, he noted that he (Mr. Southwick) had a moral repsonsibility to the patients and programs at the Rainbow Center but did not have direct responsibility over staff which was specialized in accounting, purchasing, etc.

Mr. Russ Mills noted that he was in agreement with the assessment made by Mr. Southwick inasmuch as Mr. Southwick reports to the Division of Mental Health and Retardation Services. Mr. Mills also reported that he would like to see the Division of Mental Health and Retardation Services become responsible for fiscal control. He also prefers that the budget for the Rainbow Center be separated from Osawatomie's.

Mr. Southwick characterized the Rainbow Mental Health Center as a hybrid between an institution operated by the state and a private community facility. He noted that the treatment was largely provided to patients who are more disturbed and need longer care than normal hospital programs can provide but need less care than that provided in the typical state hospital. He also noted there was a very significant difference between the two counties (Johnson and Wyandotte). He characterized Wyandotte as being a poorer county and that the residents cannot seek private psychiatric care. Seventy percent of the patients come from Wyandotte.

Representative Niles inquired as to the nature of outpatient services offered by the Rainbow Mental Health Center and how those services might differ from those services provided at Topeka State Hospital. Mr. Southwick responded by saying that the difference is really one of partial hospitalization versus outpatient care. Outpatient care is less than four hours per week whereas partial hospitalization is generally more than four hours per week and would also employ a variety of therapy models, not just a one-hour visit with a single therapist. He indicated that the program at Rainbow Mental Health Center was termed partial hospitalization in contrast to Topeka State's outpatient care.

Noting that most of the children involved in the special education programming at the institution were largely from Wyandotte County and that financial support for the program largely was provided by Wyandotte County, Senator McCray inquired as to whether the task force explored the present reimbursement from the Shawnee Mission School District. His response was that the Shawnee Mission schools had a large special education program and as a consequence, make little use of the facilities at Rainbow.

Representative Hayden directed a question at Dr. Harder, Secretary of Social and Rehabilitation Services. Representative Hayden inquired as to his views toward the present organization. Dr. Harder responded by saying that the kindest thing one could say is that the present organization is an interesting experiment. All of the parties feel frustrations with the current arrangement and he sees the need to make more clear who is actually responsible.

Representative Wingert inquired as to whether or not the counties would be willing to pick up the state funding if the state turned the facility over to the two counties. The general consensus of the group from the counties was that they were certain the counties would not pay the costs.

Dr. Ossario , Regional Office of the HEW, noted that the project (Rainbow Center) came into being becuase Mr. Robert Anderson, then chairman of the Social Welfare Board, wanted it to be. He saw it as a better alternative to building additional facilities at Osawatomie State Hospital. He did not feel the program came into being because of the availability of federal funds.

Mr. Boyts noted that, until state financial support for community mental health centers were converted to a purchase of services approach for mental health care, state subsidies to the Rainbow Mental Health Center will continue to be necessary. He

cited Colorado, California, and Minnesota as three states which had used a purchase of service system in providing state support in community mental health programs.

Senator Winter noted that he had heard rumors of salary disparity between employees at the Rainbow Center versus those of similar employees at state institutions. Mr. Southwick responded by commenting that in the original design personnel in the Rainbow Center were to be supervised by peers at Osawatomie. Consequently, there was one civil service grade difference in selected classifications. Dr. Haines then also commented that there are also class differences related to the size of the institution which exist between the other state institutions. He also noted that the Division of Personnel sets the classification and salaries of all positions.

Again referring to the earlier purchase of service approach to supporting mental health programs, Mr. Boyts commented that such an approach would encourage stronger community-oriented programs. He also expressed the belief that such an arrangement would provide more incentives and initiatives for community programs. Dr. Harder responded that one incentive of the fee for services approach is that it also provides a means to escalate costs. He cited Title XIX as a good example.

A comment was made by several of the members of the task force responsible for the report that the Committee be aware that the task force was created by the two county boards and that it was to report back to the boards. They stressed the fact that the task force report had not yet been reviewed by the boards.

Senator Winter inquired as to whether the two local boards could operate Rainbow Mental Health Center were it made a local facility in the same manner as Prairie View at Newton or High Plains at Hays. Mr. Boyts responded there was no way the local groups could operate the facility without significant state funds. He noted that the clientele of the Rainbow Mental Health Center, particularly those from Wyandotte County, do not have the same ability to pay. Senator Winter inquired of Dr. Krueger from the University of Kansas Medical Center as to whether he saw the University operating the Center without the $1.2 million of state support presently provided to the institution. Dr. Krueger responded that he was uncertain what level of state support would be required for the University of Kansas Medical Center to operate the facility.

Citing the present concerns with the present operation of the Rainbow Mental Health Center and noting that Osawatomie presently has some space available, Senator McCray inquired as to whether or not the task force explored the possibility of closing the Rainbow Mental Health Center and moving the patients to Osawatomie. The response was that the task force did not concern itself with such an option as it felt the Rainbow Unit had a vital role in the total mental health system of the state.

Senator Winter then closed the meeting by noting that the Rainbow Unit would probably be taken up again at the September meeting of the Committee. He noted that the August 18-19 meeting will be held in Topeka with the agenda devoted to the two proposals concerning the operation of state institutions and funding of community programs for mental health and retardation. The meeting adjourned at 3:10 p.m.

Prepared by Marlin Rein and Robert Epps

Approved by the Committee on:

10-10-77
(Date)

Wint Winter

PROGRAMS TO INCREASE THE NUMBER OF DOCTORS IN KANSAS

1. Increased enrollment in Medical School
   a. 1970 -- 125 in entering class
   b. 1975 -- 200 in entering class
2. Improved admissions process
   a. Addition of lay citizens
   b. College Advocacy Program
3. Expanded medical preceptorship program
   a. Minimum of two months
   b. Programs such as the one in Harper and Greensburg
4. Kansas Health Day
5. Rural Health Weekend
6. Affiliated Family Practice Programs
7. Other medical residencies in locations over the state
   a. Approximately 75 residents spent nearly 200 man-months at other locations
   b. Programs in Garden City, Halstead, Hays, Kingman, Norton, Minneola, Belleville, Phillipsburg, etc.
8. Expansion of primary care residencies
9. Office of Health Care Outreach
10. Physician Placement and Recruitment
11. Rural Health Institute
12. Locum Tenens Program
13. Continuing education for practicing physicians
    a. Programs in locations over the state
    b. More than 50 percent of Kansas physicians enroll each year
14. Services for practicing physicians
    a. Inward WATS lines
    b. Library materials
    c. Consultation services

College of Health Sciences and Hospital
Number of House Staff Distribution by Departments

GENERAL USE FUNDS

Department	FY 75	FY 76	FY 77	Requested FY 78	Actual FY 78	Requesting FY 79
Affiliated Family Practice #	---	---	1	1	1	12
Gynecology & Obstetrics	13	14	17	17	16	16
Medicine	48	59	64	64	71	78
Neurology	2	3	3	3	3	5
Ophthalmology	5	5	5	5	5	5
Otorhinolaryngology	3	4	4	4	4	4
Pathology & Oncology	15	15	15	15	15	15
Pediatrics	23	28	30	30	27	31
Rehabilitation Medicine	3	4	4	4	4	4
Psychiatry	15	15	15	15	15	19
Radiology	16	17	17	17	17	17
Surgery	41	42	42	42	42	44
Anesthesiology	13	14	14	14	14	15
Family Practice	16	20	26	50	30	32
Radiation Therapy	---	---	---	---	---	3
Wichita - Pediatrics	13	6	6	9	9	11
Wichita - Psychiatry	---	---	3	7	6	10
Wichita - Contracts	35	74	74	103	74	74
Outreach - Unassigned	17	10	---	---	---	--
	278	330	340	400	353	394

12 Positions for 1 month only

EXHIBIT C

THREE YEAR COMPARISON
M.D.'S LICENSED IN KANSAS

(PER KANSAS STATE BOARD OF HEALING ARTS)

APPLICANTS	1974	1975	1976
Out-of-State	127	117	142
Kansas	252	234	266
TOTAL	379	351	408

BREAKDOWN OF M.D.'S LICENSED IN KANSAS IN 1976

	1976 FIRST HALF	1976 SECOND HALF	1976 TOTAL
KUMC HOUSESTAFF	24	55	79
WICHITA HOUSESTAFF	14	39	53
KUMC FACULTY	9	10	19
WICHITA FACULTY	1	1	2
MENNINGER HOUSESTAFF AND FACULTY (Topeka)	5	3	8
VA AND/OR MILITARY (Kansas)	4	3	7
PRACTICING IN KANSAS	79	63	142*
	66 East of Highway 81 13 West of Highway 81	52 East of Highway 81 11 West of Highway 81	
NOT PRACTICING IN KANSAS	41	57	98
TOTAL	177	231	408

*See attached listing for location.

FISCAL YEAR 1979
THE UNIVERSITY OF KANSAS MEDICAL CENTER
COLLEGE OF HEALTH SCIENCES AND HOSPITAL

NEW AND IMPROVED PROGRAMS	EFT	AMOUNT
Residency Programs		
a. New Programs (Kansas City)		
1. Radiation Therapy Residents	3.0	36,000
b. Expanded Residency Programs (Kansas City)		
1. Orthopedic Surgery	2.0	24,000
2. Psychiatry	4.0	48,000
3. Medicine	7.0	84,000
4. Pediatrics	1.0	12,000
5. Family Practice	4.0	48,000
6. Anesthesiology	1.0	12,000
7. Neurology	1.0	12,000
c. Malpractice Insurance for Residents State Funded positions		300,000
d. Health Insurance for Residents (Kansas City and Wichita)		150,000

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Albers, Robert	Lawrence	KU	KUMC Kansas City	Med	Kansas City
Alexander, Elizabeth	Wichita	KSU	Wesley Kansas City	FP	Wichita
Allegre, Ann	Lebo	Southwestern	KUMC Kansas City	Med	Kansas City
Alsop, William R.	Garden City	KU	St. Francis Wichita	Med	Wichita
Amend, Marged	Topeka	KU			
Balentine, Larry	Fall River	KU	KUMC Kansas City	Med	Kansas City
Bassett, Paul M.	Salina	KSC-Ft. Hays	Harrisburg Harrisburg, PA	FP	Harrisburg, PA
Beard, Charles A.	Wichita	WSU	Tucson Medical Center Tucson, AZ	Med	Tucson, AZ
Bellows-Blakely, David	Topeka	Stanford U	Stanford U Stanford, CA	Psyc	Stanford, CA
Bendixen, Eric V.	Wichita	KU	St. Francis Wichita	Surg	Wichita
Bennett, Dana	Ottawa	KU	So. Colorado Family Med. Pueblo, CO	FP	Pueblo, CO
Bergman, Susan	Lawrence	SUNY-Buffalo, NY			
Bodemann, Stephen	Iola	KSC-Pittsburg			
Boehm, Douglas	Hutchinson	KU	KUMC Kansas City	Med	
Bogner, Paul	Parsons	KSU	St. Luke's Kansas City, MO	Surg	Kansas City, MO
Bowman, Patrick	Leavenworth	KU	Menorah Medical Center Kansas City, MO	Med	Kansas City, MO
Brandenberger, William	Wichita	Westmar			
Brewer, David	Overland Park	KU			
Brockman, M. Douglas	Springfield, MO	MU-Columbia, MO	U. of Oklahoma ~~Oklahoma City, OK~~	Med	Oklahoma City, OK
Brunfeldt, Joan K.	Lawrence	KU	KUMC Kansas City	Med	Kansas City

JUN 27 1977

Attachment I

ATTENDANCE

SPECIAL COMMITTEE ON WAYS AND MEANS - A

July 6-7, 1977

Name	Representing
Joe Harkins	Department of Health and Environment
Joe Meek, M.D.	Health Care Outreach - the University of Kansas
Walt Gehlbach	Division of Student Admission Boards, University of Kansas Medical Center
Jerry Slaughter	Kansas Historical Society
Mary J. Wiersma	Kansas Farm Bureau
Mrs. Robert (Lucy) Campbell	Interested Citizen, Humboldt, Kansas
Greg Reeves	Kansas City Star
Representative Burr Sifers	Twenty-fifth District
David Olson	Lawrence Journal-World
Helen M. Sims	University of Kansas Medical Center
Jim Lowman	Dean, School of Medicine Kansas City
Helen Templeton	University of Kansas Medical Center, Diagnostic Radiology
Jim Maag	Governor's Office
Ralph Kaufman, M.D.	Department of Pediatrics, KUMC
Jack Walker, M.D.	Department of Family Practice, KUMC
Dewey R. Ziegler, M.D.	Department of Family Practice, KUMC
John B. Redford, M.D.	Department of Rehabilitation Medicine
Terry Whelan	Osteopathic Medical Association
David Robinson, M.D.	University of Kansas Medical Center
Ruth Dickinson	State Division of Planning and Research
John Redford, M.D.	Rehabilitation Medicine
Daniel Urban, M.D.	Administration
Joe McFarland	Board of Regents Office
John Conard	Board of Regents Office
F.W. Masters, M.D.	Acting Chairman of Surgery
Robert Kugel, M.D.	Executive Vice Chancellor University of Kansas Medical Center
Alan Krueger, M.D.	Department of Psychiatry, KUMC
Doretha Horn	National Association of Social Workers
Jan Upshaw	National Association of Social Workers

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Buchner, David	Prairie Village	Harvard U			
Budd George T.	Pittsburg	KU	Cleveland Clinic Cleveland, OH	Med	Cleveland, OH
Buesing, Russell	Leavenworth	KU	U of Okla-Tulsa Med. Col. Tulsa, OK	Med	Tulsa, OK
Burris, Terry E.	Pittsburg	KSC-Pittsburg	Menorah Medical Center Kansas City, MO	Med	Kansas City, MO
Butterfield, Mari A.	Wichita	Tulsa U	KUMC Kansas City	Anes	Kansas City
Carey, Larry	Humboldt	KU	KUMC Kansas City	FP	Kansas City
Carter, Tony	Prairie Village	(Degree waived)	KUMC Kansas City	Path	Kansas City
Cavanaugh, Michael	Great Bend	KSC-Ft. Hays	St. Louis U Group Hospitals St. Louis, MO	Med	St. Louis, MO
Chin, Robert A.	Overland Park	U. of Michigan	KUMC Kansas City	Anes	Kansas City
Cindrich, Patrick	Prairie Village	Rockhurst			
Comer, Susan S.	Lawrence	KU	Memorial Medical Center Corpus Christi, TX	Rot	Corpus Christi, TX
Conrow, Jeffrey	Wakefield	KSU	U. of Okla. Hlth Sciences Oklahoma City, OK	Ctr. Med.	Oklahoma City, OK
Cooley, Dennis	Kansas City	KU	KUMC Kansas City	Ped	Kansas City
Cott, Gary	Belle Plaine	WSU	KUMC Kansas City	Med	Kansas City
Cronemeyer, Richard	Merriam	KU	KUMC Kansas City	Rad	Kansas City
Cvetkovich, Lorna L.	Wichita	KSC-Pittsburg	St. Luke's Kansas City, MO	OB	Kansas City, MO
DeVillier, James	St. Marys	KU	Brooke Army Medical Center San Antonio, TX	---	San Antonio, TX
Drabkin, Harry	Junction City	Berklee	Cincinnati General Cincinnati, OH	Med	Cincinnati, OH
Drange, Robert	Lawrence	KU	Wesley Medical Center Wichita	Rad	Wichita
Duncan, James M.	Wichita	KSU	Naval Regional Med. Ctr. Portsmouth, VA	Med	Portsmouth, VA

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Dyck, Eric	Wichita	K.U.	Creighton Univ.	FP	Omaha, NB
Eferakeya, Adego	Aghalopke, FO	U. of Ife, FO	U. of Behin Teaching, FO	--	FO
Ellis, Bobbie Joe	Olathe	Mid Amer.Naz. Coll.	St. Francis, Wichita	Med	Wichita
Ellis, Eileen	K.C.	Central College	U. of Arkansas-Little Rk. AR	Med	Little Rock, AR
Ferrell, Linda D.	Valley Falls	K.U.	KUMC, K.C.	Path	K.C.
Floyd, Charles	K.C.	Texas Southern, TX	- - - -	--	- - - -
Forred, Kathy	Vermillion, SD	Univ. of South Dakota	- - - -	--	- - - -
Francis, Anthony	Wichita	WSU	St. Francis Wichita	Surg	Wichita
Francis, Rudolph	New York City-NY	Fisk Univ.	Meharry Med College Nashville, TN	--- - -	Nashville, TN
Garth, Karen Eaton	Salina	Cal. Tech.	KUMC, K.C.	Surg	K.C.
Gilliland, Mark	Leon	K.U.	U. of Texas Affl. Houston, TX	Surg	Houston, TX
Goodwin, Mary K.	Augusta	WSU	St. Francis Wichita	FP	Wichita
Greenberg, Joel	Prairie Village	Case Western Reserve	St. Luke's Kansas City, MO	Med	Kansas City, MO.
Grimes, Charles K.	Wichita	M I T	- - - -	--	- - - -
Guardia, David K.	Pittsburg	KSC of Pittsburg	- - - -	--	- - - -
Hagan, Robert C.	Wichita	K.U.	St. Francis Wichita	Ob	Wichita
Hale, William	Leawood	Washburn U.	- - - -	--	- - - -
Hardiman, Sharyl	Lawrence	KSU	St. Joseph Denver, CO	Ob	Denver, CO
Harms, Willard	Halstead	Okla. Christian Coll.	KUMC, K.C.	Surg	K.C.
Harvey, Timothy	Topeka	Washburn,U.	- - - -	--	- - - -

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Hastings, Mary	K.C.	K.U.	KUMC, K.C.	Psyc	K.C.
Henderson, John	Prairie Village	K.U.	KUMC, K.C.	Med	K.C.
Hendrickson, Kathryn	Hillsboro	Tabor College	Children's Mercy K.C., MO	Ped	K.C., MO
Hill, Lary M.	Hays	K.U.	St. Francis Wichita	Ped	Wichita
Holmes, John	Lawrence	K.U.	KUMC, K.C.	Med	K.C.
Holmes, Robert W.	Wichita	K.U.	St. Francis Wichita	Med	Wichita
Horine, Jon Alvin	Iola	KSC of Pittsburg	- - - -	--	- - - -
Hudson, Peter C.	Overland Park	degree waived	KUMC, K.C.	Surg	K.C.
Huycke, Maureen D.	Pittsburg	K.U.	KUMC, K.C.	Med	K.C.
Jacobs, Elizabeth	Wichita,	Marquette	St. Francis Wichita	Med	Wichita
Johnson, Carol A.	Marion	KSU	Wesley Med Center Wichita	FP	Wichita
Johnson, Larry	Salina	K.U.	- - - -	--	- - - -
Jones, Bruce H.	Prairie Village	Harvard Univ.	- - - -	--	- - - -
Jost, Gary D.	Hillsboro	Tabor College	St. Francis Wichita	Surg	Wichita
Joyce, Jeffrey T.	Ulysses	K.U.	St. Luke's Kansas City, MO	Anes	Kansas City, MO
Karniski, Larry P.	Prairie Village	K.U.	- - - -	--	- - - -
Kimmel, Kenneth	Wichita	K.U.	KUMC, K.C.	Med	K.C.
Kovac, Anthony	Kansas City	St. Louis Univ.	(Matching Program 1978)		
Kuhn, Nancy Jo	Topeka	K.U.	Balboa Heights, CT	Rot	Balboa Heights, CT
Law, Therese	Ellinwood	K.U.	KUMC, K.C.	Med	K.C.

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L. .TION
Leo, Jan Elizabeth	Shawnee Mission	K.U.	KUMC, K.C.	Surg	K.C.
Lonergan, John J.	Salina	KSU	Gorgas Balboa Heights, OT	Rot	Balboa Heights, O
MacDougall, Margaret	Shawnee Mission	K.U.	Wayne State Affl.Program Detroit, MI	Med	Detroit, MI
MacFarlane, Larry	Prairie Village	Purdue Univ.	Riverside Methodist Columbus, OH	Rot	Columbus, OH
Magee, Lawrence	Fort Scott	K.U.	Washington County Washington	--	Washington
Markwell, Robert E.	Hays	K.U.	- - - -	--	- - - -
Martin, Wade H.	K.C.	K.U.	St. Louis Univ. St. Louis, MO	Med	St. Louis, MO
Martinez, Kay	Hutchinson	K.U.	KUMC, K.C.	Med	K.C.
Massey, Andrew D.	Nickerson	K.U.	St. Francis Wichita	Med	Wichita
McBoyle, Marilee F.	Abilene	KSC of Emporia	St. Francis Wichita	Surg	Wichita
McCarthy, James T.	Overland Park	K.U.	Mayo Graduate School of Med Rochester, MN	Med	Rochester, MN
McCune, Mark A.	Stafford	K.U.	Mayo Graduate School of Med Rochester, MN	Derm	Rochester, MN
McGeeney, Terry	Seneca	Benedictine College	KUMC, K.C.	FP	K.C.
McIntyre, Don Lee	Mulvane	Univ. of Florida	Univ. of Florida Gainsville, FL	FP	Gainsville, FL
Meinhardt, Ernest	Manhattan	KSU	U.S. Regional Navy Med Center Oakland, CA	Psyc	Oakland, CA
Miller, Thomas G.	Kansas City	K.U.	N. Kansas City Memorial N. Kansas City, MO	FP	N. Kansas City, M
Mills, Vernon	Washington, D.C.	Howard Univ.	D.C. General Washington, D.C.	Ped	Washington, DC
Morgan, Randall	Hutchinson	K.U.	Edward Sparrow Lansing, MI	OB	Lansing, MI
Mosier, Michael	Manhattan	KSU	St. Joseph Wichita	FP	Wichita
Munoz, Phillip	Wichita	K.U.	Northwestern U. Med School Chicago, IL	Path	Chicago,

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L[illegible]ION
Murphy, John P.	Shawnee	K.U.	St. Luke's Kansas City, MO	Rot	Kansas City, MO
Myrick, Stephen	Liberal	K.U.	St. Francis Wichita	Surg	Wichita
Navickas, Leonard	Overland Park	degree waived	KUMC, K.C.	FP	K.C.
Nelson, Paul W.	Kansas City	Dartmouth	U. of Texas Med Branch Galveston, TX	Surg	Galveston, TX
Nickell, Margaret	Norman, OK	K.U.	St. Luke's Kansas City, MO	Med	Kansas City, MO
Nielsen, Mary	Wichita	Bethany	St. Francis Wichita	Path	Wichita
O'Dell, Michael	Overland Park	KSU	KUMC, K.C.	FP	K.C.
Oelschlaeger, Mary	Salina	K.U.	Univ. of California Irvine, CA	FP	Irvine, CA
O'Neal, Lynn W.	Overland PArk	K.U.	Naval Regional Med Ct. Oakland, CA	Rot	Oakland, CA
Osbern, Lida N.	Kansas City	K.U.	KUMC, K.C.	Med	K.C.
Parker, Craig	Topeka	K.U.	KUMC, K.C.	Anes	K.C.
Parr, Catherine L..	Rossville	KSU	KUMC, K.C.	Ob	K.C.
Pinnick, Robert	Ulysses	K.U.	KUMC, K.C.	Med	K.C.
Pittenger, Joyce	Weir	K.U.	KUMC, K.C.	Ped	K.C.
Plemons, Ronald	Medicine Lodge	KSU	David Grant Med Center Travis AFB, CA	Med	CA
Porter, Charles	Overland Park	SMU	KUMC, K.C.	Med	K.C.
Pray, Claudia	Great Bend	K.U.	Children's Mercy Kansas City, MO	Ped	Kansas City, MO
Pringle, Scot G.	Tribune	Baylor	Edward Sparrow Lansing, MI	Ob	Lansing, MI
Ragland, Charles	Newton	K.U.	- - - -	--	- - - -
Ransom, Willard	Williamsburg	KSU	KUMC, K.C.	FP	K.C.

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Rardin, Mary	Topeka	Washburn	St. Francis Wichita	Surg	Wichita
Reimer, Darla J.	Hillsboro	Tabor	St. Francis Wichita	FP	Wichita
Riordan, Terrance	Kansas City	Rockhurst	Letterman Army Med. Ctr. San Francisco, CA	Ped	San Francisco, CA
Schism, Mary Jane	Kansas City	KU	KUMC Kansas City	OB	Kansas City
Schoenleber, Michael	Wichita	KU	KUMC Kansas City	Ped	Kansas City
Sheftel, David N.	Kansas City	KU	Wylers Children Chicago, IL	Ped	Chicago, IL
Sherraden, Terry	Salina	KSU	U. of Kentucky Med. Ctr. Lexington, KY	Med	Lexington, KY
Shevrin, Daniel	Topeka	Antioch			
Shook, Thomas Lee	Kansas City	Harvard			
Short, Bruce H.	Fredonia	KU	KUMC Kansas City	Med	Kansas City
Singer, Glen DeRoy	Savonburg	KU			
Smith, Perry	Inman	KU	St. Francis Wichita	FP	Wichita
Smith, William	Lawrence	KU	KUMC Kansas City	Rad	Kansas City
Sourk, Robert	Holton	KU	U of Iowa Iowa City, IA	Med	Iowa City, IA
Spake, Robert	Shawnee Mission	KU	St. Luke's Kansas City, MO	Surg	Kansas City, MO
Steinbauer, Jeffrey	Manhattan	KSU	Wesley Med. Ctr. Wichita	FP	Wichita
Stevens, Philip	Tonganoxie	KSC-Pittsburg	Baptist Memorial Kansas City, MO	FP	Kansas City, MO
Stewart, Randy	Lawrence	KU	Wesley Med. Ctr. Wichita	FP	Wichita
Strauss, William	Kansas City, MO	KU	KUMC Kansas City	Med	Kansas City
Streit, Jerome	Downs	KSC-Ft. Hays	St. Joseph Wichita	FP	Wichita

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L. .TION
Strickland, Gary R.	Sonoma, CA	(Degree waived)	USC-LAC Med. Ctr. Los Angeles, CA	Path	Los Angeles, CA
Strickland, Robert	Overland Park	(Degree waived)	Naval Aerospace Regional Med. Ctr., Pensacola, FL	FP	Pensacola, FL
Taylor, Steven Lee	Manhattan	KSU	Scott AFB Belleville, IL	Rot	Belleville, IL
Tosone, Steven R.	Wichita	KU	Baylor Univ. Med. Ctr. Houston, TX	Surg	Houston, TX
Vernon, Mary C.	Topeka	KU	KUMC Kansas City	FP	Kansas City
Vierthaler, Stephen	Spearville	St. Marys-Plains	St. Francis Wichita	Med	Wichita
Vincent, Lawrence	Shawnee Mission	Harvard	St. Vincent's New York, NY	Rad	New York, NY
Waldby, Gail	LeSueur, MN	KU	KUMC Kansas City	Surg	Kansas City
Waldorf, James	Greensburg	KU	Mayo Graduate Schl. of Med. Rochester, MN	Surg	Rochester, MN
Waldschmidt, Mike	Wichita	KSC-Ft. Hays	U. of Alabama Birmingham, AL	Surg	Birmingham, AL
Ware, Joe	ElDorado	Washburn	U. of Texas Affl. Houston, TX	Ped	Houston, TX
Waterman, Jack	Waldoboro, ME	U of Maine	Wilmington Med. Ctr. Wilmington, DE	FP	Wilmington, DE
Whitaker, Mark	Kansas City	(Degree waived)	Children's Mercy Kansas City, MO	Ped	Kansas City, MO
Williams, Becky J.	Hill City	Okla. Christ	U of Ark. for Med. Sciences Little Rock, AR	Ped	Little Rock, AR
Wilson, Frances C.	Los Angeles, CA	Pomona	KUMC Kansas City	Med	Kansas City
Winger, Raymond	Johnson	KU	KUMC Kansas City	FP	Kansas City
Wolf, Patrick	Wichita	Kansas Newman	St. Joseph Wichita	Path	Wichita
Woodhams, J. Trevor	Wichita	KU	Georgia Baptist Atlanta, GA	Flex	Atlanta, GA

M.D. GRADUATES IN 1976

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L ION
Abernethy, Darrell	Beloit	KU	Jackson Memorial Miami, Fl.	Med	Miami, Fl.
Alleman, Robert	Bartlesville, Ok.	Ok. Univ.	St. Luke's K.C., Mo.	Surg	K.C., Mo.
Allen, Timothy	K.C.	Westminster College	St. Luke's K.C., Mo.	Rad	K.C., Mo.
Amend, Douglas	Great Bend	KU	St. Luke's K.C., Mo.	Rot	K.C., Mo.
Artzer, Dennis	Topeka	Washburn Univ.	KUMC K.C.	Med	
Bachman, Barbara	Wichita	KU	St. Luke's K.C., Mo.	Rot	K.C., Mo.
Barker, Steven	Winfield	KU	St. Joseph Wichita	FP	Wichita
Bascom, George	Manhattan	KU			
Batty, Larry	Raytown, Mo.	UMKC	KUMC K.C.	OB	K.C.
Beahm, Thomas	Independence	KSC-Pittsburg	St. Francis Wichita	Surg	Valley Center
Berstler, Michael	Ft. Madison, Ia.	Ottawa Univ.	Mercy-St. Luke's Davenport, Ia.	FP	Davenport, Ia.
Blackman, Jacques	El Dorado	KU	St. Francis Wichita	FP	Wichita
Bolt, Michael	Parsons	KSC-Pittsburg	St. Francis Wichita	Surg	Wichita
Bonacum, Glenn	Huntington, Ca.	Sonoma St. College	Highland General Oakland, Ca.	Surg	Oakland, Ca.
Bowman, Karen	Salina	KU	St. Luke's K.C., Mo.	Rot	K.C., Mo.
Bradley, J. Douglas	Greensburg	KU	Baptist Memorial K.C., Mo.	FP	K.C., Mo.
Brandsted, Mark	McPherson	KU	KUMC K.C.	Surg	K.C.
Braun, Alan Lee	Prairie Village	KU	Wesley Medical Center Wichita	Med	Wichita
Brewer, Joseph	Ulysses	KU	St. Luke's K.C., Mo.	Med	K.C., Mo.
Broxterman, Steven	Topeka	Washburn Univ.	KUMC K.C.	FP	K.C.

M.D. GRADUATES IN 1976

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Bruning, Roger	Overland Park	KSC-Emporia	Baptist Memorial K.C., Mo.	FP	K.C., Mo.
Bumpas, Timothy	Derby	Friends			
Byrd, Richard	Ottawa	KU	KUMC K.C.	Med	K.C.
Calkins, John	Shawnee Mission	Princeton	KUMC K.C.	OB	K.C.
Carlin, James	Topeka	Methodist Univ.	KUMC K.C.	Anes	K.C.
Cashier, Dwight	Shawnee	KU	N. K.C. Memorial N. K.C., Mo.	FP	N. K.C., Mo.
Charette, Richard	Overland Park	Gonzaga Univ.	Children's Mercy K.C., Mo.	Ped	K.C., Mo.
Chown, Mark	Shawnee	KU	Presbyterian St. Luke's Chicago, Il.	Surg	Chicago, Il.
Coate, Sarah	Prairie Village	Mt. Holyoke College	St. Francis Wichita	Med	Wichita
Collins, Raymond	Pomona	USMA	KUMC K.C.	OB	
Conde, Gary	Overland Park	KU	St. Francis Wichita	FP	Wichita
Corder, Stephan	Highland	KU	Mercy-St. Luke's Davenport, Ia.	FP	Davenport, Ia.
Crouch, Steven	Topeka	Baker Univ.	KUMC K.C.	Ped	K.C.
Dell, Robert	Olathe	Texas Christian	Methodist Dallas, Tx.	OB	Dallas, Tx.
Desch, Larry	Topeka	Washburn Univ.	UM Med Center Columbia, Mo.	Ped	Columbia, Mo.
Diacon, William	Wellington	KU	Wesley Medical Center Wichita	Rad	Wichita
Diederich, Paul	Greenleaf	KSU	Lyons Medical Center Lyons		Lyons
Donnelly, William	K.C.	Regis College	KUMC K.C.	FP	K.C.
Dunlap, John	Manhattan	KSU	KUMC K.C.	Med	K.C.
Dyer, Joseph	Springfield, Mo	Southwest Mo.	Carney Boston, Ma.	Path	Boston, Ma.

M.D. GRADUATES IN 1976

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Edwards, Henry	Waterville	KU	Wesley Medical Center Wichita	Med	Wichita
Ellis, Darrel	Manhattan	KSU			
Evans, Dan	Salina	KU	KUMC K.C.	Med	K.C.
Filley, Warren	Pratt	KU	U. of Ok. Oklahoma City, Ok.	Med	Oklahoma City, Ok.
Fiore, Joseph	Harrisonville, Mo.	KU	Menorah Medical Center K.C., Mo.	Med	K.C., Mo.
Franklin, Benjamin	K.C.	KU	KUMC K.C.	Med	K.C.
Gardner, John	Topeka	Washburn Univ.			
Gertzen, Joyce	Cut Bank, Mt.	KU	UM Med Center Columbia, Mo.	Med	Columbia, Mo.
Ginder, Perri	K.C., Mo.	St. Louis Univ.			
Griswold, Stephen	Lawrence	KU	St. Luke's K.C., Mo.	Med	K.C., Mo.
Groner, Christopher	Shawnee Mission	Dartmouth College	N.C. Baptist Winston-Salem, N.C.	FP	Winston-Salem, N.C
Guziec, Robert	Wichita	WSU			Chicago, Il.
Hackney, Wendell	Atlanta, Ga.	Morehouse College	Wayne State U. Affil. Detroit, Mi.	OB	Detroit, Mi.
Hancock, Danny	Mankato	KU	Ohio State Univ. Columbus, Oh.	Med	Columbus, Oh.
Hansen, Frank	Shawnee Mission	KU			
Harris, Kenneth	Topeka	KU	Univ. Wash. Affil. Seattle, Wa.	Surg	Seattle, Wa.
Harstine, Lillian	El Dorado	Phillips Univ.	Wesley Medical Center Wichita	Med	Wichita
Hendrickson, Jon	Leawood	KU	Children's Mercy K.C., Mo.	Ped	K.C., Mo.
Hibarger, Walter	Wichita	Grinnell College			
Hoffmann, Sandra	Pittsburg	KU	Carney Boston, Ma.	Med	Boston, Ma.

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NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOC.
Hood, Jerry	Hoisington	KU	N.C. Memorial Chapel Hill, N.C.	Ped	Chapel Hill, N.C.
Hornbaker, Charles	Hutchinson	Bethany Nazarene Col.	KUMC K.C.	FP	K.C.
Hunninghake, Ronald	Seneca	Benedictine	Wesley Medical Center Wichita	FP	Wichita
Jensen, Jack	Holton	Washburn Univ.	Hermman Houston, Tx.	Surg	Houston, Tx.
Jernigan, Randal	Council Grove	KSU	Ia. Luthern Des Moines, Ia.	FP	Des Moines, Ia.
Jones, Cameron	Pittsburg	KU	KUMC K.C.	Med	K.C.
Jones, Moses	Enfanla, Ca.	Ca. State College Los Angeles, Ca.			
Karnaze, Gregory	K.C.	Dartmouth College			
Karniski, Walter	K.C., Mo.	KU	KUMC K.C.	Ped	K.C.
Katz, Stephen	Topeka	Brandeis Univ.	Menninger Foundation Topeka	Psyc	Topeka
Kaup, Danny	Goodland	USMA	Madigan Army Med Center Tacoma, Wa.		Tacoma, Wa.
Keeler, Linda	Salina	KU	KUMC K.C.	Psyc	
Klontz, William	El Dorado	Mid American Nazarene	St. Francis Wichita	Psyc	Wichita
Koksal, Thomas	Garden City	KU	KUMC K.C.	FP	K.C.
Lavin, Mark	Los Angeles, Ca	UCLA	USC Med Center Los Angeles, Ca.	Rot	Los Angeles, Ca.
Levene, Robert	Prairie Village	KU	Menorah Medical Center K.C., Mo.		K.C., Mo.
Lewis, Frank	Ft. Scott	KSU-Pittsburg	St. Luke's K.C., Mo.	Med	K.C., Mo.
Lewis, Sherry	K.C.	Mt. Holyoke College			
Lindholm, Gerald	Windom	KU	KUMC K.C.	FP	K.C.
Liu, John	Prairie Village	John Hopkins	Texas Medical Branch Galveston, Tx.	Med	Galveston, Tx.

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NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOC. N
Lowe, Bruce	Independence	Bringham Young	Vanderbilt Affil. Nashville, Tn.	Surg	Nashville, Tn.
Majure, Joyce	Shawnee Mission	Yale Univ.	U. of Co. Med Center Denver, Col	Surger	Denver, Co.
Mangold, Joel	K.C., Mo.	KU	KUMC K.C.	Anes	K.C.
Martin, Craig	Manhattan	KSU	Sheppard & Enoch Pratt Baltimore, Md.	Psyc	Baltimore, Md.
Maybury, Marsha	K.C.	KU	KUMC K.C.	Ped	K.C.
McBride, Ann	Lawrence	KU	St. Luke's K.C., Mo.	OB	K.C.
McBride Nancy	Lawrence	KU	St. Luke's K.C., Mo.	OB	K.C.
McCray, Stephen	Hiawatha	KU	KUMC K.C.	Anes	K.C.
McCroskey, Lon	Prairie Village	Harvard	Mayo Clinic Rochester, Mn.	Surg	Rochester, Mn.
McCusker, Kevin	Halstead	N.D. Univ.	KUMC K.C.	Med	K.C.
McKissick, Robert	Minneola	Geneva College	Wesley Medical Center Wichita	FP	Wichita
McPhee Mark	K.C., Mo.	Pomona College	Beth Israel Boston, Ma.	Med	Boston, Ma.
Meyer, Jack	Norton	KU	Hopkins-Torver Madisonville, Ky.	FP	Madisonville, Ky.
Miller, Donald	Topeka	Washburn Univ.	Henry Ford Detroit, Mi.	OB	Detroit, Mi.
Minns, Garold	McPherson	McPherson College	St. Francis Wichita	Med	Wichita
Mitchell, Andrew	Prairie Village	Pomona College	St. Luke's K.C., Mo.	Med	K.C., Mo.
Morrison, Michael	Wichita	KU	KUMC K.C.	OB	K.C.
Morton, Roscoe	Dallas, Tx.	Colorado College	St. Francis Wichita	Med	Wichita
Newland, William	Toronto	KU	Mary Imogene Bassett Cooperstown, N. Y.	Med	Cooperstown, N.Y.
Nickell, Barry	Salina	KU	St. Luke's K.C., Mo.	Rot	K.C., Mo.

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Parmet, Allen	Fairway	USAF Academy	David Grant USAF Travis AFB, Ca.	Surg	Travis AFB, Ca.
Parsons, Carolynn	Manhattan	KSU	St. Francis Wichita	FP	Wichita
Perryman, John	Wichita	Yale Univ.	St. Luke's K.C., Mo.	Med	K.C., Mo.
Petelin, Joseph	K.C.	Benediction	KUMC K.C.	Surg	K.C.
Petro, Christopher	Topeka	Univ. of Co.	Univ. of Az. Affil. Edu. Tucson, Az.	Psyc	Tuscon, Az.
Petzold, Robert	Lakewood, Ca.	Ca. State College LB	DeWitt Army Belvoir, Va.	FP	Ft. Belvoir, Va.
Phelps, David	Overland Park	KU	Wesley Medical Center Wichita	FP	Wichita
Proberts, Karen	Kinsley	KSU			
Rajewski, Richard	Victoria	KU	St. Joseph Wichita	FP	Wichita
Rauktis, Robert	Overland Park	KU			
Richards, Dean	Baldwin City	Baker Univ.	St. Luke's K.C., Mo.	Rot	K.C., Mo.
Richter, Don	Great Bend	KSU			
Robertson, Edward	K.C.	KU	KUMC K.C.	Anes	K.C.
Rosen, Larry	Prairie Village	Washburn Univ.	St. Luke's K.C., Mo.	Med	K.C., Mo.
Ruhlen, Thomas	Baldwin City	Baker Univ.	Swedish Seattle, Wa.	Surg	Seattle, Wa.
Sabates, Roland	Shawnee Mission	KU	Univ. of Ia. Iowa City, Ia.	Opth	Iowa City, Ia.
Santoscoy, Thomas	El Paso, Tx.	Univ. of Tx.-El Paso	Cleveland Clinic Cleveland, Oh.	Surg	Cleveland, Oh.
Satake, Robert	Fort Scott	KU	KUMC K.C.	Psyc	K.C.
Saunders, Michael	Wellington	KU	St. Francis Wichita	Med	Wichita
Schifman, Ronald	Overland Park	KU			

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Schnose, Gregory	Hays	KU	St. Francis Wichita	Med	Wichita
Schroll, John	Hutchinson	KU	KUMC K.C.	OB	K.C.
Setter, Kenneth	Wichita	KU	Gorgas Balboa Heights, Canal Zone	Rot	Balboa Heights, Canal Zone
Sheern, Mark	Garnett	KU	Wesley Medical Center Wichita	FP	Wichita
Shockey, Mark	Abilene	KU	KUMC K.C.	Med	K.C.
Shore, Douglas	Massapequey, NY	Northwestern Univ.	Nassau County Med Center E. Meadowbrook, N.Y.	Med	E. Meadow, N.Y.
Sidlinger, Robert	Hutchinson	KSU	Wesley & St. Francis Wichita	Ped	Wichita
Sillix, Dale	Lawrence	KU	Wayne State Univ. Affil. Detroit, Mi.	Med	Dearborn, Mi.
Silverberg, David	Shawnee Mission	KU	KUMC K.C.	Med	K.C.
Simpson, Dennis	Satanta	KU	Univ. of Co. Med Center Denver, Co.	Med	Denver, Co.
Smith, David	Liberal	Southwestern Univ.	KUMC K.C.	Surg	K.C.
Sosinski, Richard	K.C.	KU	St. Francis Wichita	Med	Wichita
Spense, Michael	Fort Scott	KU	Wesley Medical Center Wichita	FP	Wichita
Spielman, Steve	Prairie Village	KU			
Stevens, Laura	Garnett	KU	Menorah Medical Center K.C., Mo.	OB	K.C., Mo.
Stevenson, Jean	Leawood	KU			
Talbott, William	Wichita	KU	David Grant Med Center Travis, AFB, Ca.	Surg	Fairfield, Ca.
Tenny, Robert	Ratown, Mo.	KU	Mayo Clinic Rochester, Mn.	Surg	Rochester, Mn.
Teubner, Donn	Wichita	KU			
Thatcher, Gregory	Englewood, N.J.	KU	KUMC K.C.	FP	K.C.

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Thedinger, Bradley	Shawnee Mission	Rockhurst College	Mercy Hospital Denver, Co.	FP	Denver, Co.
Thompson, David	Topeka	Washburn Univ.			
Tilzer, Lowell	Shawnee Mission	KU	KUMC K.C.	Path	K.C.
Tippin, Steve	Wichita	KU			
Tobias, Roger	Lyons	KU	St. Francis Wichita	Surg	Wichita
Turner, Ernest			Children's Mercy K.C., Mo	Ped	K.C., Mo.
Valentine, John	Wellington	KU	St. Luke's K.C., Mo.	Rot	K.C., Mo.
Vancura, Stephen	Manhattan	KSU	Letterman Army Med Center San Francisco, Ca.	Med	San Francisco, Ca.
Van Houden, Charles	Neodesha	KSU-Emporia	St. Francis Wichita	Surg	Wichita
Viets, Joseph	Brazilton	KSU-Pittsburg	KUMC K.C.	Anes	K.C.
Wagner, Robert	Ellinwood	KU	KUMC K.C.	Med	K.C.
Walter, Donnal	Sterling	Sterling College	KUMC K.C.	Ped	K.C.
Waxman, Michael	K.C., Mo.	Coe College	KUMC K.C.	Med	K.C.
Weilert, Michael	Roeland Park	KU	Univ. of Co. Affil. Denver, Co.	Surg	Denver, Co.
Wells, Max	Winfield	KU	Univ. of Co. Med Center Denver, Co.	Path	Denver Co.
Wilkins, James	Quenemo	KU	KUMC K.C.	FP	K.C.
Williams, Bret	Lawrence	KU			
Williamson, John	Prairie Village	Duke Univ.	KUMC K.C.	Surg	K.C.
Wilson, Donald	Hutchinson	St. Benedict			
Wilson, Modena	Wichita	McPherson College	Univ. Madison, Wi.	Ped	Madison, Wi.

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Winblad, James	Winfield	KU	Good Samaritan Phoenix, Az.	Rot	Phoenix, Az.
Winn, Randall	Shawnee Mission	Tulane Univ.	KUMC K.C.	Rad	K.C.
Wise, Joseph	K.C.	KU	Univ. of Ne. Affil. Omaha, Ne.	Ped	Omaha, Ne.
Wisner, John	Roeland Park	St. Thomas Sem	KUMC K.C.	Psyc	K.C.
Wittman, Anthony	Garden City	KU			
Wolfley, Gerald	Omega	KU	Scottsdale Memorial Scottsdale, Az.	FP	Scottsdale, Az.
Wymore, Craig	Osawatomie	KU	St. Luke's K.C., Mo.	Surg	K.C., Mo.
Zubowicz, Vincent	Osawatomie	KU	Grady Memorial Atlanta, Ga.	Surg	Atlanta, Ga.

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NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCA
Alderson, Thomas	Lawrence	KU	St. Francis Wichita	Med	Wichita
Anderson, Mark	Seneca	KU	Stanford U. Med Center Palo Alto, Ca	Neuro Surg	Palo Alto, Ca.
Andrisevic, James	Kansas City	KSU	Hennepin County Minneapolis, Mn.	Surg	Minneapolis, Mn.
Ansbacher, Linda East	Springfield, Mo.	S.W. Mo. St. Univ.	Univ. of Mo. Med Center Columbia, Mo.	Path	Columbia, Mo.
Arnold, Claudia	Alma	KSU	St. Francis Wichita	Med	Wichita
Austin, Arthur	Hill City	KSC-Ft. Hays	St. Francis Wichita	Med	Wichita
Bagby, Jack	Prairie Village	KU	Mayo Graduate Sch of Med Rochester, Mn.	Med	Rochester, Mn.
Bambara, John	Somerville	Notre Dame	KUMC	Path	Kansas City
Barnes, Maurice	Overland Park	KU	Univ. of Mo. Med Center Columbia, Mo.	Med	Columbia, Mo.
Bates, Michael	Prairie Village	KU	KUMC	OB	Kansas City
Bauer, William	Highland	KU	Good Samaritan Phoenix, Az.	Psyc	Phoenix, Az.
Bell, Mark	Kansas City	KSU	St. Luke's Kansas City, Mo.	Rot	Kansas City, Mo.
Berg, Gordon	Shawnee Mission	Baker Univ.			Concordia
Bidnick, Terrence	Kansas City	KU	KUMC	Surg	Kansas City
Bishop, Rodney	Wichita	KU	KUMC	Med	Kansas City
Bogner, Phillip	Parsons	KSU	Wesley Med Center Wichita	FP	Wichita
Bosiljevac, Joseph	Emporia	KSC-Emporia	Charity New Orleans, La.	Med	New Orleans, La.
Boyle, George	Hoisington	KSC-Emporia	Univ. of Tx. Med. Branch Galveston, Tx.	Med	Galveston, Tx.
Butler, Doris	Great Bend	KSU	St. Joseph Wichita	FP	Wichita
Calbeck, John	Pratt	KU	Harper Detroit, Mi.	Med	Southfield, Mi.

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Caldwell, Sherrie	Chanute	KU	KUMC	Path	Kansas City
Cannon, Jack	Pittsburg	KSC-Pittsburg	KUMC	Rad	Kansas City
Cannon, Michael	Wichita	WSU	KUMC	Path	Kansas City
Carlile, John	Caney	KU	KUMC	Ped	Kansas City
Chartrand, Stephen	Manhattan	KU	Children's Med Center Dallas, Tx.	Ped	Dallas, Tx.
Chatelain, John	Manhattan	KSU			San Antonio, Tx.
Chismire, Kevin	Topeka	Notre Dame	Brooke Army Med Center Ft. Sam Houston, Tx.	Med	Ft. Sam Houston, Tx.
Coates, Nancy	Topeka	Duke	St. Luke's Kansas City, Mo.	Surg	Kansas City, Mo.
Cohlmia, George	Wichita	KU	Highland General Oakland, Ca.		Oakland, Ca.
Cossette, Jerrold	Mission	UMKC	KUMC	Med	Kansas City
Cox, Kent	Lawrence	Ks. Wesleyan	Univ. of Washington Seattle, Wa.	Ophth	Seattle, Wa.
Cox, Terry	Salina	KU	St. Luke's Kansas City, Mo.	Med	Kansas City, Mo.
Craig, William	Topeka	KSU	Wm. Beaumont Army Med Center, El Paso, Tx.		Wl Paso, Tx.
Crawford, David	Great Bend	non-degree	Baptist Memorial Memphis, Tn.	Surg	Memphis, Tn.
Cudney, Barbara	Trousdale	KSU	Menorah Med Center Kansas City, Mo.	Med	Kansas City, Mo.
Currey, Kathleen	Kensington	KU	Somerset Somerville, N.J.		Somerville, N.J.
Custer, Galen	Olathe	KU	Ohio State Univ Columbus, Oh.	Med	Columbus, Oh.
Czarlinksy, Charles	Shawnee Mission	KU	Children's San Francisco, Ca.	Med	San Francisco, Ca.
Davis, Chester	Neosho Falls	KU	KUMC	FP	Kansas City
DeHaven, Charlene	Hoisington	KU	Good Samaritan Phoenix, Az.	Med	Phoenix, Az.

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Dellasega, Mark	Pittsburg	KSC-Pittsburg	Duke Univ. Med Center Durham, N.C.	Med	Durham, N.C.
Dempsey, Barbara	Wichita	KSU	St. Francis Wichita	Med	Wichita
Dunagin, William	Topeka	KU	St. Luke's Kansas City, Mo.	Med	Columbia, Mo.
Edwards, John	Wichita	KU	Univ. Wash. Affiliated Seattle, Wa.	Rehab Med	Seattle, Wa.
Elteto, Aron	Alliance, Oh.	Kent State	Walter Reed Army Med Center, Washington, D.C.	Path	Silver Spring, Md.
Fahrenholtz, Randall	Sylvia	Sterling	Wesley Med Center Wichita	FP	Wichita
Farney, Kent	Leawood	KSU	KUMC	OB	Kansas City
Fleske, Leonard	Larned	KU	St. Francis Wichita	Surg	Wichita
Foster, Robert	Kansas City	KU	KUMC	Surg	Kansas City
Friesen, Randall	Newton	Bethel	Medical Col. of Toledo Arlington at Detroit	OB	Toledo, Oh.
Gibson, James	Wichita	WSU	Univ. of Tx. at San Antonio, Tx.	Surg	San Antonio, Tx.
Goertz, Kenneth	Prairie Village	Occidental	KUMC	Ped	Kansas City
Goldman, Barry	Kansas City	Miami Univ. Oh.	KUMC	Med	Kansas City
Grandison, Kathleen	Cedar Point	KSU	John Peter Smith Ft. Worth, Tx.	FP	Ft. Worth, Tx.
Gray, Captain	Vallen City, N.D.	N.D. State Univ.	KUMC	Med	Kansas City
Green, Debora	Peoria, Ill.	U. of Illinois	K. C. General Kansas City, Mo.	Med	Kansas City
Griffith, John	Shawnee Mission	KU	St. Luke's Kansas City, Mo.	Rot	Kansas City, Mo.
Hacker, David	Leawood	KU	N.Y. State U.-King County Brooklyn, N.Y.	Rot	Brooklyn, N.Y.
Hall, Reginald	Kansas City	KU	St. Luke's Kansas City, Mo.	Rot	Kansas City, Moo.
Harbin, Gary	Salina	KU	KUMC	Surg	Kansas City

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Hardin, Creighton	Prairie Village	Wash. Univ.	Univ. of Utah Affiliated Salt Lake City, Ut.	Ped	Salt Lake City, Ut
Hart, Kelly	Fort Scott	KSC-Pittsburg	KUMC	Med	Kansas City
Hatch, Dennis	Benkelman, Nb.	KSC-Fort Hays	Wesley Med Center Wichita	FP	Wichita
Hays, Thomas	Wichita	KU	St. Joseph Wichita	FP	Wichita
Hendricksen, David	Sioux City, Io.	Buena Vista Col.	no graduate medical training		San Bernadino, Ca.
Henry, Kathryn	Eldorado	non degree	KUMC	Ophth	Kansas City
Hesse, Frederick	Hutchinson	KU	St. Francis Wichita	Med	Wichita
Hubbell, Gail	Shawnee Mission	UC-Berkely	Highland Oakland, Ca.	Med	Oakland, Ca.
Irwin, Richard	Johnson	KU	KUMC	Ophth	Kansas City
Jackson, Janice	Topeka	KU	KUMC	Psych	Kansas City
Jackson, Michael	Topeka	KU	St. Francis Wichita	Med	Wichita
Jeffries, Barry	Leawood	KU	KUMC	Rad	Kansas City
Jeffries, Rhonda	Wichita	KU	KUMC	Ped	Kansas City
Jeppesen, Judith	Greenleaf	KSU	Allentown Allentown, Pa.	Rot	Allentown, Pa.
Johnson, Richard	Lindsborg	Bethany College	Wilford Hall Lackland AFB San Antonio, Tx.	Rad	San Antonio, Tx.
Jones, Mark	Topeka	KU			
Jones, Nolan	Wichita	WSU	Martin Luther King, Jr. Los Angeles, Ca.	OB	Los Angeles, Ca.
Jones, William	Wichita	KU	St. Mary's San Francisco, Ca.	Rot	San Francisco, Ca.
Karlin, Charles	Hays	KSC-Fort Hays	KUMC	Rad	Kansas City
Keller, Robert	Wichita	WSU	KUMC	Psych	Kansas City

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Kelling, Ernest	Overland Park	Harvard	St. Luke's Kansas City, Mo.	Surg	Kansas City, Mo.
Kofender, Vicki	Ames, Tx.	UMKC	Cook County Chicago, Il.	FP	Chicago, Il.
Koontz, Judith	Kansas City				
Kupperberg, Jerald	Overland Park	Middleburg Col.	Rhode Island Providence, RI	Ped	Providence, RI.
Lack, Gaylin	Wichita	Friends Univ.	St. Francis Wichita	Surg	Wichita
Lash, Ray	Osawatomie	KU	KUMC	Med	Kansas City
Locke, Thomas	Prairie Village	KU	St. Luke's Milwaukee, Wi	Rot	Milwaukee, Wi
Manion, Daniel	Lawrence	KU	KUMC	FP	Kansas City
Marsh, Connie	Kansas City	Ottawa Univ.	K. C. General Kansas City, Mo.	Med	Kansas City, Mo.
Mason, Richard	Leawood	USMA			Deceased
McCoy, Michael	Hiawatha	KU	Mayo Graduate School Rochester, Mn.	Med	Rochester, Mn.
McIntosh, Marvin			St. Joseph-Mercy Pontiac, Mi.	OB	Pontiac, Mi.
McKenzie, Paula	Topeka	Tulane Univ.			Deceased
McNeal, Richard	Topeka	USNA	Navy Regional Med Center San Diego, Ca.	Ped	San Diego, Ca.
McNickle, George	Ashland	Trinity Univ.	Wesley Med Center Wichita	FP	Wichita
Megaffin, Bernard	Pratt	WSU	Wesley Med Center Wichita	Med	Wichita
Mertz, Janet	Mound City	non degree	St. Luke's Kansas City, Mo.	Med	Wichita Falls, Tx.
Miller, Donald	Lawrence	KU	Univ. of Mo. Med Center Columbia, Mo.	Med	Columbia, Mo.
Mocnik, Jack	Pittsburg	KSC-Pittsburg	Balboa Naval Regional San Diego, Ca.	Rad	San Diego, Ca.
Morgan, Candice	Kansas City	Ca. State Polytech	Presbyterian Med Center Denver, Co.	Med	Denver, Co.

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NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCA
Moritz, Ernest	Doylestown, Pa.	Brown Univ.	KUMC	Med	Kansas City
Muther, Richard	Kansas City	KU	KUMC	Med	Kansas City
Myers, Percy	Kansas City, Mo.	N.W. Mo. State U.	KUMC	Med	Kansas City
Nagorney, David	Kansas City	non degree	Mayo Graduate School Rochester, Mn.	Surg	Rochester, Mn.
Neis, Thomas	Parsons	KSC-Pittsburg	Univ. of Mo. Columbia, Mo.		Columbia, Mo.
Nelson, Bryan	Shawnee Mission	Stanford	Children's Mercy Kansas City, Mo.		Kansas City, Mo.
Nichols, Jeff	Stockton	KU	Menninger Foundation Topeka	Psych	Topeka
Nordstrom, James	Overland Park	Luther College	Univ. of Iowa Iowa City, Io.	Med	Iowa City, Io.
Norris, Jo	Topeka	KU			
Norton, Kenneth	Garden City	KU	Wesley Med Center Wichita	Med	Wichita
Orrison, William	Meade	KU	Madison General Madison, Ws.	Path	Madison, Ws.
Pendergrass, Kelly	Kansas City	KU	Baptist Memorial Memphis, Tn.	Med	Memphis, Tn.
Peterie, Jerry	Kinsley	KSU	Wesley Med Center Wichita	Med	Wichita
Petterson, Jon	Syracuse	KU	Baptist Memorial Kansas City, Mo.	FP	Kansas City, Mo.
Phelps, Craig	Stockton	KU	Tulsa Family Practice Tulsa, Ok.	FP	Tulsa, Ok.
Plapp, Fred	Mission	KU	Univ. of Chicago Clinics Chicago, Il	Path	Chicago, Il.
Pogson, George	Pittsburg	KU	St. Luke's Kansas City, Mo.	Med	Kansas City, Mo.
Pommerenke, Forrest	Great Bend	Harvard	Kansas City General Kansas City, Mo.	Med	Kansas City, Mo.
Prather, Stephen	Wichita	KSU	Norwalk Norwalk, Ct.		Norwalk, Ct.
Price, Pat	Atchison	KU	W. Virginia Univ. Morgantown, W. Va.	Med	Morgantown, W. Va.

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NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCA
Reser, Juliana	Winchester	KU	St. Joseph Wichita	FP	Wichita
Rhodes, Timothy	Wichita	Friends Univ.	Kessler AFB Med Center Biloxi, Ms.	Ped	Biloxi, Ms.
Ricci, Robert	Lenexa	KU	KUMC	Med	Kansas City
Richards, Jon	Hays	KU	Miriam Providence, RI	Med	Providence, RI
Robinson, John	Attica	KU	St. Francis Wichita	Med	Wichita
Roembach, Jeanine	Lenexa	non degree			
Rope, Douglas	Kansas City, Mo.	U. of Tx.-Austin	St. Vincents New York City, NY	Rot	New York City, NY
Sanders, Gloria	Atchison	Creighton	St. Joseph Wichita	Path	Wichita
Schelbar, Emil	Lawrence	KU	Baroness Erlanger Chattanooga, Tn.	Med	Chattanooga, Tn.
Schukman, Jay	Hays	KSC-Fort Hays	KUMC	FP	Kansas City
Sebree, Robert	Salina	KSU	KUMC	FP	Kansas City
Shuss, John	Parsons	KU	Charity New Orleans, La.	Surg	New Orleans, La.
Smiley, Scott	Norton	Washburn	KUMC	Rad	Kansas City
Snow, Arthur	Wichita	WSU	KUMC	FP	Kansas City
Solsky, Marilyn	Prairie Village	KU	Henry Ford Detroit, MI		Detroit, MI
Stein, Richard	Overland Park	KU	Charity New Orleans, La.	Med	New Orleans, La.
Stitt, Ronald	Shawnee Mission	KU	KUMC	Surg	Kansas City
Stoecker, Willeford	Manchester, Mo.	Unive of Wyoming			
Stoffer, Robert	Halstead	Washburn	Good Samaritan Phoenix, Az.		Phoenix, Az.
Stucky, Eric	Lawrence	KU	Good Samaritan Phoenix, Az.		Phoenix, Az.

M.D. GRADUATES IN 1975

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCA
Sturgeon, Janet		KU	KUMC	Ped	Kansas City
Sullivan, James	Emporia	Johns Hopkins	Univ. of Hawaii Honolulu, Ha	Med	Honolulu, Ha.
Taylor, Sarah	Wichita	Cornell	KUMC	Med	Kansas City
Tucker, Sheridan	Mission	UMKC	KUMC	Psych	Kansas City
Van Slyke, Nancy	Wichita	KU	Kansas City General Kansas City, Mo.	Med	Kansas City, Mo.
Wallace, Jeffrey	Manhattan	Univ. of Colorado	St. Francis Wichita	Surg	Wichita
Weaver, Steven	Belleville	KSU	David Grant AF Travis AFB, Ca.	Surg	Travis AFB, Ca.
Weidensaul, David	Wichita	KU	St. Francis Wichita	Med	Wichita
Welch, Maura	Hutchinson	non degree	Gorgas Balboa Heights	Rot	Balboa Heights Canal Zone
Werth, Darrell	Hays	KSC-Fort Hays	St. Francis Wichita	Surg	Wichita
Wigglesworth, Anne	Topeka	Radcliffe	Miriam Providence RI	Med	Providence, RI
Wilson, Mary	Wichita	Washington Univ.	KUMC	Ped	Kansas City
Witt, Richard	Kansas City	UMKC	Southern Colorado Gen Pueblo, Co.	FP	Pueblo, Co.
Wood, Edward	Wichita	KU	St. Luke's Kansas City, Mo.	Med	Kansas City, Mo.
Wright, Alvin	Pawnee Rock	KU	Madigan Army Med Center Tacoma, Wa.	FP	Tacoma, Wa.
Willeford, James			Madigan Army Med Center Tacoma, Wa.		Tacoma, Wa.

M.D. GRADUATES IN 1974 (4 yr program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L[illegible]ION
Abrams, James II	Kansas City	Univ of PA	Los Angeles Co Harbor Torrance, CA	SURG	Rochester, MN
Aldis, Stephen K.	Fort Scott	KU	Nethodist Dallas, TX		Dallas, TX
Anderson, Anthony K	Prairie Vill	Westmont	Mayo Grad Sch of Med Rochester, MN	MED	Rochester, MN
Barton, Jean Campbell	KC, MO	Univ of PA	Childrens Mercy Hosp. KC, MO	PED	KC, MO
Basow, William M.	Wichita	KU	Mercy & St. Lukes Hosp Cedar Rapids, IA	FP	Cedar Rapids, I
Beller, Thomas A.	Topeka	KU	St. Lukes Hosp KC, MO	MED	Kansas City
Benoit, Charles H.	Shawnee Miss	Carleton	New England Dicconess Boston, MA	SURG	Belmont, MA
Berstein, Joseph M.	Shawnee Miss	KU	San Diego Co Univ Hosp San Diego, CA	SURG	Kansas City
Biggs, James D.	Lyons	KU	Wesley Med Ctr Wichita		Abilene
Bosken, Donald W.	Winfield	WSU	St. Francis Hosp. Wichita	ROT	Thomasville, NC
Bredehoeft, Steven J.	Overland Pk	KU	Duke Univ, Med Ctr. Durham, NC	PATH	Durham, NC
Bubb, Stephen K.	Topeka	KU	KUMC	SURG	Kansas City
Buss, Brian E.	Wichita	Macalester	Oregon State Hosp Salem, OR	PSY	Salem, OR
Carver, Larry A.	Wichita	Southwestern	Menninger Sch of Psyc Topeka St. Hosp, Topeka	PSYC	Topeka
Cathcart-Rake William	Prairie Vill	Univ of CO	KUMC	MED	Kansas City
Clendenin, Robert K.	Mission	KU	St. Lukes Hosp KC, MO		Overland Park
Coker, James E.	Desoto	KU	KUMC		Kansas City
Courtney, Sherry E.	Manhattan	KSU	Childrens Mercy Hosp KC, MO	PED	KC, MO
Danitschek, Carl N.	Lawrence	USNA	KUMC	ANES	Chesapeke, VA
Day, Howard A.	Kansas City	Bethany	KUMC	MED	Kansas City

M.D. GRADUATES IN 19 74 (4 yr program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L[illegible]ION
Deal, Terry D.	Liberal	Arkansas	William Beaumont Gen. Army Hosp. El Paso, TX		El Paso, TX
Donnelly, Francis M.	Kansas City	Regis	KUMC	ANES	Mission
Dunn, Daniel R.	Wichita	WSU	Southside Hosp. Bay Shore, NY	FP	Colby
Edwards, William D.	Wichita	KU	KUMC	PATH	St. Paul, MN
Elkins, Robert L.	Ok	KU	St. Lukes Hosp KC, MO	ROT	Kansas City
Enright, Steven K.	Wichita	KU	Highland General Oakland, CA	ROT	Bella Vista, AR
Ervin, John E.	Prairie Vill	Notre Dame	KUMC	MED	Kansas City
Fast, Robert E.	Atchinson	KU	KUMC	OB	Atchinson
Fowler, Dennis L.	Wichita	Phillips	St. Lukes Hosp KC, MO	SURG	KC, MO
Friesen, Dale W.	Prairie Vill	Bethel	KUMC	ANES	Lawrence
Garrigues, Ned W.	Salina	Morehead	Naval Hosp San Diego, CA	SURG	San Diego, CA
Gendel, Michael H.	Topeka	Brandeis	KUMC	PED	Denver, CO
Gerstenberger, Dea	Shawnee Miss	Baker	Allentown Hosp Allentown, PA		Rochester, MN
Gessler, James A.	Wichita	Creighton	St. Francis Hosp Wichita	ROT	Houston, TX
Giessel, Michael	Larned	KU	St, Francis Hosp Wichita	ROT	Overland Park
Graham, David E.	Prairie Vill	KSU	Wesley Med, Center Wichita, KS		Fort Worth, TX
Green,	Prairie Vill	KU			Cleveland Hts,
Grinstead, Dan S.	Bonner Springs	KSU	KUMC	MED	Kansas City
Hacker, Douglas A.	Leawood	KU	Charity Hosp of LA New Orleans, LO	ROT	Red Lake, MN
Harbrecht, James J.	Overland Pk	Rice	St. Lukes Hosp KC, MO	MED	KC, MO

M.D. GRADUATES IN 1974 (4 yr program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L. .TION
Harlan, John J.	Kansas City		St. Francis Hosp Wichita Falls	SURG	Wichita
Haskins, Robert J.	Manhattan	KSU	Wesley Medical Ctr Wichita	FP	Ft. Collins, C
Hauxwell, Jon P.	Eudora	KU	KUMC	FP	Kansas City
Hempler, Sharon K,	Bird City	KU	Univ of San Antonio San Antonio, TX	PED	San Antonio, T
Herrman, Adam L.	Hays	KSC	St. Francis Wichita		Wichita
Huffstutter, Sue E.	Arkansas City	KU			Kansas City
Hunt, Patrick T.	Smithville,MO	UMKC	St. Lukes KC, MO		Smithville, MO
Irons, Kerry D.	Minneola	Ks Wesleyan			Waco, TX
Jackson, Douglas R.	Overland Park	Duke			San Monica, CA
Jenkins, Lisa J.	Wichita	KU	Emanuel Portland, OR	ROT	Salinas, CA
Jobson, Vernon W.	Kansas City	KU	Good Samaritan Phoenix, AZ	OB	Phoenix, AZ
Johnson, Donald R.	Kansas City	Baker	Naval Oakland, CA	ROT	Oakland, CA
Jones, Roy G.	Wichita	WSU	St. Francis Wichita	ROT	Wichita
Joyce, Steven T.	Ulysses	KU	St. Lukes KC, MO		Lenexa
Kahn, Norman B.	Shawnee Miss	Univ of PA	San Francisco Gen San Francisco, CA	FP	San Francisco,
Kantor, James H.	Wichita	KU	Kaiser Foundation San Francisco, CA	PED	San Francisco,
Kathol, Mary Holma	Leawood	KU	Good Samaritan Phoenix, AZ	ROT	Iowa City IA
Kathol, Roger G.	Shawnee Mission	Univ of PA	Good Samariton Phoenix, AZ	MED	Phoenix, AZ
Keller, James P.	Pittsburg	KSU	Wesley Medical Center Wichita	MED	
Klotz, Stephen A.	Olathe	KU	Syracus Medical Ctr. Syracus, NY	MED	Syracuse, NY

M.D. GRADUATES IN 1974 (4 yr program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L. .TION
Krebs, Richard S.	Edmonds, WA	WA State Univ	Wesley Medical Center Wichita	FP	Wichita
Lauver, Mary A.	DeSoto	WSU	KUMC	PED	Kansas City
Lee, Charles K.	Topeka	Washburn	Univ of Chicago Chicago, IL	SURG	Kansas City
Leiker, Joseph	Kansas City	Non-degree	KUMC	RAD	Wichita
Lerner, Bruce E.	Mission Hills	WA. Univ	KUMC	ANES	Kansas City
Loftus, Loretta S.	Shawnee Miss	Tulane	KUMC	MED	Kansas City
Lonergan, James H.	Wichita	WSU	Childrens Mercy KC, MO	PED	KC, MO
Luzier, Thomas L.	Mission Hills	Westminister	Fitzsimmons Army Denver, CO	ROT	Denver, CO
McMahon, William	Kansas City	KU	KUMC	PSYC	Salt Lake City
Marx, William L.	Kansas CIty	Rockhurst	St. Lukes KC, MO		Rochester, MN
Mauk, John Dean	Conway	KU	St. Francis Wichita	ROT	Battendorf, IA
Miles, John M.	Shawnee Miss	SMU	St. Lukes KC, MO	MED	Kansas City, M
Mockton, Laurance	Shawnee Miss	KU	KUMC	SURG	Kansas City
Moore, James E.	Salina	Notre Dame	St. Joseph Wichita	FP	Wichita
Morford, Ronald G.	Hays	KSC-Fort Hays			
Moss, Leonard M.	Overland Park	Washburn	Univ of NB Omaha, NB	MED	Omaha, NB
Neuschafer, Darrel	Holyrood	KSC-Fort Hays	Wesley Medical Center Wichita	OB	Hutchinson
Nevin, Donald R.	Horton	KU	Sacred Heart Spokane, WA	ROT	Spokane, WA
Nowlin, Nancy S.	Lawrence	KU	Wesley Medical Center Wichita	ROT	Wichita
Nyquist, Steven R.	Wichita	WSU	KUMC	PATH	Kansas City

M.D. GRADUATES IN 19 74 (4 yr program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L[illegible]ION
Parham, Verdon W.	Wichita	WSU	USAF Medical Center Scott AFB, IL	FP	O'Tallon, IL
Potter, Donald E.	Chanute	KU	Providence Waco, TX	FP	Waco, Texas
Preskorn, Sheldon	Wichita	WSU	KUMC	PATH	St. Louis, MO
Pruitt, John C.	Wichita	WSU	St. Lukes KC, MO	SURG	Kansas City
Randles, Michael J.		KU	St. Francis Wichita	MED	Wichita
Rasmusson, Jarold	Lindsborg	KSU	Gorgas Balboa Heights Canal Zone	ROT	Lindsborg
Read, William T.	Coffeyville	KU	Univ. HOsp. of Madison Madison, WI	PED	Madison, WI
Richert-Boe, Kathryn	Wichita	Cornell	K.C. General KC,MO	MED	Oregon
Riederer, Mary L.	KC, MO	Manhattanville	St. Lukes KC, MO	ROT	San Francisco,C
Roeder, Eva V.	Wichita	KU			
Rosen, David	Prairie Vill	Northwestern	KUMC	PED	Kansas City
Ross, David K.	Arkansas City	Nondegree	St. Francis Wichita	ROT	Kansas City
Ryan, Robert P.	Overland Park	KU	USAF Medical Center Wright-Pat AFB, OH	ROT	Columbia OH
Schubert, Albert, W	Great Bend	KU	KUMC	OPTH	Charleston, IL
Schultz, Steven L.	Larned	KSU	Arizona State Phoenix, AZ	Psyc	Phoenix, AZ
Simpson, Joseph A.	Andover	Rockhurst	Univ of San Antonio San Antonio, TX	Psyc	San Antonio, TX
Smith, John L.	Clearwater	Southwestern	St. Francis Wichita		Wichita
Smith, Stephen B.	Larned	KU	KUMC	MED	Overland Park
Smith, William E.	Shawnee Miss	Drake	IN Univ. Med Center Indianopolis, IN	MED	Kexington, KY
Soder, Eric	Wichita	KU	St. Lukes KC, MO		KC, MO

M.D. GRADUATES IN 1974 (4 yr program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Spencer, John H.	Wichita	KU	St. Lukes KC, MO		KC, MO
Stanton, Stephen K.	Iola	Nondegree	Santa Clara Valley San Jose, CA	ROT	San Jose, CA
Stout, Philip L.	Abilene	KU	Kings Co MEd Center Brooklyn, NY	ROT	Brooklyn
Stumpff, Lawrence C.	DeSoto	KSU			Wichita
Swan, Gaylord Gaylord	Wichita	KU	Genesee Rochester, NY	ROT	Rochester, NY
Tatlock, Thomas W.	Wichita	KU	KUMC	MED	Madison, WI
Teichgraeber, Joseph	Chapman	KSU	Univ of NB Omaha, NB	MED	Omaha, NB
Thomas, Christopher	Shawnee Miss	KU	Cincinnati Gen Cincinnati, OH	MED	Cincinnati, OH
Thompson, James D.	Shawnee	KSU	United St. Paul, MN	ROT	Minneapolis, MN
True, James D.	Americus	KU	St. Lukes KC, MO		Kansas City
Ulrich, Brian K.	Topeka	Creighton	Stormont Vail Topeka, KS	MED	Topeka
Velander, Robert D.	Independence	Arkansas St	Baptist Memorial Memphis, TN	ROT	Memphis, TN
Verhage, Carroll L.	Cawker City	KU	St. Joseph Wichita	FP	
VonLintel, THomas A.	Hays	KU	KUMC	ANES	Kansas City
Walsh, Thomas E.	Onaga	Notre Dame	St. Lukes KC, MO	ROT	Onaga
Waring, James M	Wichita	KU	St. Lukes KC, MO	MED	KC, MO
Weber, Tim J.	Topeka	Notre Dame	Doctors Seattle, WA	FP	Seattle, WA
Wesbrook, Clyde W.	Winfield	Arizona	USAF Med Center Travis AFB, CA	OB	Travis AFB, CA
Wheeler, Nicky R.	Hutchinson	Okla Christian	St. Francis Wichita		Wichita
Widner, Victor R.	Pittsburg	KU	Jacksonville Jacksonville, FL	MED	Jacksonville, FL

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M.D. GRADUATES IN 1974 (4 yr program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Williamson, Paul	Kansas City	KU	Wesley Med Center Wichita	FP	Lexington
Wisner, Steven P.	Hays	Wisconsin	Butterworth Grand Rapids, MI	PED	KC, MO
Wurm, Michael J.	Shawnee		Iowa Lutheran Des Moines, IA	FP	Des Moines, IA
York, Robert K.	Kansas City	Wm, Jewell	Wesley Med Center Wichita	FP	Homestead, FL
Zeller, Darrell	Kansas City	St. Louis Univ	St. Lukes KC, MO	OB	KC, MO

M.D. GRADUATES IN 1974 (3 Yr. Program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Adams, John	Overland Park	KU			K.C.
Ahlers, Paul	Wichita	Rutgers			Hershey, Pa.
Aldis, Stephen	Fort Scott	KU	Methodist Dallas, Tx.	Rot	Dallas, Tx.
Barnes, Rodney	Council Grove	KSU	St. Joseph Wichita	FP	Wichita
Bartley, James	Powhattan	KSU-Chanute	KUMC K.C.	Ped	K.C.
Bell, Charlotte	Prairie Village	KU			San Francisco, Ca.
Berry, John	K.C.	KU	St. Luke's K.C., Mo.	Rot	K.C., Mo.
Beugelsdyk, Henry	Wichita	WSU	KUMC K.C.	Anes	K.C.
Bhasker, Ravi	Lawrence	KU	St. Francis Wichita	Med	Carrizzo, N.M.
Black, Charles	Lawrence	KU	Children's Mercy K.C., Mo.		K.C., Mo.
Boles, Robert	Dodge City	KU	Univ. of Mi. Affil. Ann Arbor, Mi.	Surg	K.C.
Borello, Danny	Pittsburg	KSU-Pittsburg	St. Luke's K.C., Mo.	Rot	K.C., Mo.
Bowser, Robert	Joliet, Il.	Ball State	KUMC K.C.	Anes	K.C.
Bredfeldt, James	Abilene	KU	KUMC K.C.	Med	Columbia, Mo.
Brooks, William	Salina	KSU	St. Luke's K.C., Mo.	Rad	Shawnee Mission
Brothers, Mary	Leavenworth	Saint Marys			Leavenworth
Brown, Delorise	Byhalia, Ms.	WSU	Cleveland Clinic Cleveland, Oh.	Med	Cleveland, Oh.
Carpenter, Frank	Manhattan	KSU	Wieford Hall Lackland, AFB, Tx.	Med	Lackland AFB, Tx.
Caughron, Michael	Manhattan	KSU	St. Mary's Duluth, Mn.	Rot	Warrond, Mn.
Chartrand, Stephen	Leawood	KU	Univ. of Tx. SW Med Center Dallas, Tx.		Dallas, Tx.

M.D. GRADUATES IN 1974 (3 Yr. Program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Cohen, Marvin	Prairie Village	KU			
Collins, Jack	Roeland Park	KU			Modesto, Ca.
Conner, Barbara	El Dorado	KU	Baylor Houston, Tx.	FP	Houston, Tx.
Darrah, C. Joy	Wichita	KU	Wesley Medical Center Wichita	Rad	Wichita
Dawson, Mark	Wichita	UMKC	Univ. of Toronto Canada	Med	E. Lansing, Mi.
Donnelly, Edward	K.C.	KU			Pittsburgh, Pa.
Douville, Douglas	Overland Park	USAFA			
Elterman, Floyd	Topeka	KU	Baptist Memorial K.C., Mo.	FP	K.C., Mo.
Fairchild, Richard	Topeka	Washburn			K.C.
Ferns, Francis	Pittsburg	KSU-Pittsburg	St. Luke's K.C., Mo.	Rot	Malmstrom AFB, Mt.
Fisher, Ray	K.C.	KU	Wesley Medical Center Wichita	Med	Wichita
Fleming, Colette	Pittsburg	KSU-Pittsburg	Omaha, Nb.	Ped	Omaha, Nb.
Fox, Deanna	Plainville	KU	KUMC K.C.	Anes	K.C.
Friedrich, Eugene	Shawnee Mission	Yale	Univ. of Co. Med Center Denver, Co.	Psyc	Denver, Co.
Garwood, Jan	Hays	KSU-Fort Hays	St. Francis Wichita	Rot	Wichita
Gaughan, Michael	Shawnee Mission	KU			Shawnee Mission
Gerber, Allen	Argonia	WSU	Wesley Medical Center Wichita	Surg	Wichita
Gold, Larry	Prairie Village		Jacksonville Educ. Prg. Jacksonville, Fl.	Med	Jacksonville, Fl.
Gorenz, David					
Grady, Ann	Prairie Village	St. Louis Univ.	Med College of Va. Richmond, Va.		Richmond, Va.

M.D. GRADUATES IN 1974 (3 Yr. Program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LO ON
Graves, Kathryn	Hutchinson	KU	St. Luke's K.C., Mo.	Rot	K.C., Mo.
Green, Elaine	K.C.	KU	KUMC K.C.	Psyc	K.C.
Grimaldi, Gary	Pittsburg	KSU	St. Luke's K.C., Mo.	OB	K.C., Mo.
Grossman, Harvey	Prairie Village	Tulane	Children's Mercy K.C., Mo.	Ped	K.C., Mo.
Haire, William	Iola		KUMC K.C.	FP	K.C.
Harper, Larry	Pittsburg	KU			Spokane, Wa.
Harrison, Paul	Wichita	WSU	Wesley Medical Center Wichita	Surg	Wichita
Hill, Rodney	K.C.	Greenville	KUMC K.C.	Med	K.C.
Hodgson, David	Hutchinson	KU	KUMC K.C.	Med	K.C.
Horton, Billy	K.C.	Doane College	Scott & White Memorial Temple, Tx.	Med	Temple, Tx.
Hostetter, Robert	Manhattan	KSU	San Joaquin General Stockton, Ca.	Rot	Spring Hill
Ihrig, Roger	Goodland	KU	KUMC K.C.	Psyc	K.C.
Iliff, Richard	Prairie Village	KU	Fort Bragg Fayetteville, N.C.	FP	Ft. Bragg, N.C.
Jantz, Gerald	Prairie Village	KU			Memphis, Tn.
King, Daniel	Wichita	Carleton	Vanderbilt Univ. Affil. Nashville, Tn.	Ped	Fairborn, Oh.
Korte, Stephen	Arkansas City	KU	Temple, Tx.	Med	Temple, Tx.
Krehbiel, Mark	McPherson	Bethel	Wesley Medical Center Wichita	FP	Wichita
Kunz, Stephen	Leawood	Princeton	St. Luke's K.C., Mo.		K.C., Mo.
Li, Ulysses	K.C.	Princeton		Ped	Madison, Wi.
Liesmann, George	Topeka	Vanderbilt	KUMC K.C.	Surg	K.C.

M.D. GRADUATES IN 1974 (3 Yr. Program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Liesmann, Jean	Salina	KSU	KUMC K.C.	Med	K.C.
Loney, John	Marion	KU	St. Francis Wichita	Med	Wichita
Losh, David	K.C.	Ottawa	St. Joseph Mercy Mason City, Ia.	FP	Mason City, Ia.
McDonald, Philip	Beloit	Stanford		Ped	
MacDougall Margaret					
Martin, Joseph	K.C.	Regis	Norwalk, Ct.		Norwalk, Ct.
Martinez, John	Hutchinson	KU	KUMC K.C.	Med	K.C.
Matthews, Earl	Teascott	KU	KUMC K.C.	Surg	Army
Mawdsley, Michael	Wichita	KSU	St. Francis Wichita	Rot	Wichita
Meyer, Orvel	Palmer	KSU			Albuquerque, N.M.
Miller, Freeman	Hutchinson	KU			Memphis, Tn.
Mosier, Steven	Manhattan	KSU	St. Joseph Wichita	FP	Wichita
Mundis, Richard	K.C.	KU	St. Luke's K.C., Mo.	Med	K.C., Mo.
Nauer, Paula	Jennings	KSU-Ft. Scott	KUMC K.C.	FP	K.C.
Norris, Jo A.					
Odgers, Rodney	Seneca	KU	St. Francis Wichita	Med	Pittsburg
Old, Jerry	Garden City	KU	KUMC K.C.	FP	K.C.
Palmberg, Kent	Topeka	KU		Med	Wichita
Parks, Gary	Ellsworth	KU	St. Francis Wichita	Med	Wichita
Parks, Pamela	Wichita	William Woods	Wesley Medical Center Wichita	Path	Wichita

M.D. GRADUATES IN 1974 (3 Yr. Program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOC
Perdue, William	Topeka	KU			Salt Lake City, Ut.
Perkins, William	K.C.	KU	KUMC K.C.	Ped	K.C.
Petterson, Dennis	Wichita	KU	Wesley Medical Center Wichita	Med	Wichita
Pirotte, Thomas	Wichita	Creighton			Omaha, Nb.
Portnoy, Joseph	St. Louis, Mo.	Washington	St. Louis Univ. General St. Louis, Mo.	Ped	Manhasset, N.Y.
Ralstin, James	Wichita	Hardin-Simmons			Columbus, Oh.
Ramsey, Terroll	Colcord, Ok.	Okla. State Univ.			
Ransom, Kenneth	Wichita	KU	KUMC K.C.	Surg	K.C., Mo.
Richards, Dallas	Atwood	KSU			K.C.
Robinson, John	Wichita	KU	KUMC K.C.	Anes	K.C.
Robl, David	Wichita	WSU	St. Francis Wichita	Med	Wichita
Rope, Douglas	K.C., Mo.	Univ. of Tx.-Austin	Med College of Toledo Toledo, Oh.	Rot	N.Y., N.Y.
Sammer, Michael	Wichita	WSU		Med	K.C., Mo.
Sandberg, Chris	El Dorado	KU	Baptist Memorial K.C., Mo.	FP	K.C., Mo.
Scheel, Bradley	Buhler	Bethany Nazarene			Detroit, Mi.
Sedo, Phillip	K.C.	KU	St. Luke's Fargo, N.D.	Rot	Rugby, N.D.
Shade, Ronnie	Coffeyville	KSU-Pittsburg	William Beaumont General El Paso, Tx.	Med	Ft. Campbell, Ky.
Shields, Thomas	El Dorado	KSU	St. Francis Wichita	Surg	Wichita
Sifers, Timothy	Shawnee Mission	KU	KUMC K.C.	Surg	K.C.
Simmons, [illegible]bert	Lawrence	KU	St. Francis Wichita	Med	Wichita

M.D. GRADUATES IN 1974 (3 Yr. Program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Sinning, Gary	Holton	KU	McKennan Sioux Falls, S.D.	FP	Sioux Falls, S.D.
Smith, Timothy	Wichita	KU	KUMC K.C.	Med	K.C.
Stitt, Ronald	Prairie Village	KU			K.C.
Steuwe, Brad	Lawrence	KU	KUMC K.C.	Med	K.C.
Talbott, Lawrence	Wichita		KUMC K.C.	Path	K.C.
Thompson, Frederick	Caldwell	KU	St. Luke's Mercy Cedar Rapids, Ia.	FP	Cedar Rapids, Ia.
Torrence, Michael	Overland Park	MU-Columbia	KUMC K.C.	Ped	K.C.
Toth, John	K.C.	KU	Scott Air Force Base Belleville, Il.	FP	O'Fallon, Il.
Toth, Nancy	Belleville	KSU	Scott Air Force Base Belleville, Il.	FP	O'Fallon, Il.
Trombold, Walter	Wichita	KU	KUMC K.C.	Med	K.C.
Trotter, Roger	Norwich	KU	Ball Memorial Muncie, Il.	FP	Minneola
Vrtiska, John	Minneola	KSU	St. Joseph Phoenix, Az.	OB	Phoenix, Az.
Wait, Juliette	Mission	KU	KUMC K.C.	Med	K.C.
Walker, Donald	Shawnee Mission	KU	KUMC K.C.	Psych	K.C.
Warren, Donald	La Harpe	KU	KUMC K.C.	Surg	K.C.
Watkins, Steven					
Wesselius, Lewis	Topeka	KU	Univ. of Az. Tuscon, Az.	Med	Tuscon, Az.
Wilhelm, Donald	Shawnee Mission	Duke	KUMC K.C.	Med	K.C.
Wilkinson, Larry	McDonald	KU	St. Francis Wichita	Rot	USAF, Pickett, Va.
Woodhouse, Charles	Wichita	KU	St. Francis Wichita		Wichita

M.D. GRADUATES IN 1974 (3 Yr. Program)

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Worthman, John	Prairie Village	KU	Naval San Diego, Ca.	Med	San Diego, Ca.
Yost, James	Pittsburg	KU		Med	Temple, Tx.

M.D. GRADUATES IN 1973

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Atkins, C.D.	Wichita	KU	St. Lukes KC,MO		KC,MO
Anderson, L.R.	Williamsburg	KSU	St. Lukes KC,MO	MED	Wellington
Anderson, T.G.	Topeka	KU	L.A. Co. L.A., CA	ROT	L.A. CA.
Barnes, J.R.	Arkansas City	KU	KUMC	MED	Topeka
Barton, R.M.	Wichita	Harvard	Duke Durham, NC	SURG	Gaithersburg, M
Bauer, M.L.	Prairie Village	KU	Kauikeolani Hawaii	PED	KC,MO
Baxter, W.R.	Salina	Stanford	KUMC	FP	Salina
Beezley, M.J.	Girard	USAFA	Travis AFB CA	SURG	Fairfield CA
Beezley, N.K.	Girard	KU			Fairfield CA
Bettis, R.B.	Wichita	WSU	Doctors Seattle, WA	FP	Edmonds, WA
Bhasker, C.	Wichita	KU	PHS San Francisco, CA	SURG	Amarillo, TX
Black, J.F.	Pratt	TEX A&M	St. Francis Wichita	SURG	Wichita
Black, W.L.	Pratt	TEX A&M	Letterman St. Francis, CA	SURG	Denver, CO
Blakely, C.A.	Kansas City	KU	UC San Francisco, CA	SURG	Medford, OH
Boehm, O.R.	Shawnee	Seton	Buffalo Buffalo, NY	MED	Orchard Park, N
Brock, A.L.	Wichita	WSU	St. Lukes KC,MO	ROT	KC,MO
Browning, W.R.	Wichita	Williams	Wesley Wichita	FP	Madison
Budd, J.C.	Pittsburg	KU	Travis AFB CA	MED	Ogden, UT
Burke, J.E.	Gove	KU	Mercy Cedar Rapids, IA	FP	Marshalltown IA
Burson, M.A.	Shawnee	Ottawa	KUMC	REHAB MED	Liberty, MO

M.D. GRADUATES IN 1973

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Cessna, J.E.	Pittsburg	KSC-Pittsburg	St. Francis Wichita	SURG	Wichita
Ciskey, W.J.	Topeka	Washburn	Wesley Wichita	FP	Eureka
Code, W.E.	Lisbon, ND	Jamestown	KUMC	FP	Williston, ND
Cooper, Kent	Kansas City	Rockhurst	KUMC	PSYCH	Pittsburg
Corder, R.L.	Highland	KU	KUMC	OBN	St. Joseph, MO
Coyle, J.F.	Coffeyville	KU	Univ. of PA Philadelphia	MED	Salt Lake City,
Daglen, J.J.	Topeka	Benedictine	Univ. of Arizona Tuscon	FP	Caldwell ID
Day, C.L.	Chanute	KU	KUMC	PSYC	Shawnee Mission
Deschner, W.H.	Leawood	KU	KUMC	OB	Billings, MT
Dworzack, D.L.	Coffeyville	Washington	KUMC	MED	Shawnee Mission
Edmonds, P.J.			KUMC	MED	Kansas City
Egelhof, R.H.	Wichita	WSU	Sydney Sydney, Australia	ROT	Wichita
Esch, J.G.	Pittsburg	Notre Dame	Cleveland Clinic OH	SURG	Cleveland OH
Ferguson, R.L.	Menlo	KU	KUMC	MED	Shawnee Mission
Florez, J.P.	Kansas City	KU	KUMC	MED	Shawnee Mission
Forster, L.G.	Topeka	Ks. Wesleyan	Wesley Wichita	FP	Salina
Fortin, D.G.	Shawnee Mission	Notre Dame	St. Lukes KC,MO	ROT	Grand Rapids, M
Fretz, W.D.	Liberal	KSC-Fort Hays	Menorah KC,MO	SURG	Ashland
Geis, D.A.	Circleville	Washburn	L.A. Co. Los Angeles, CA	ROT	Circleville
Haight, J.M.	KC,MO	KU	KUMC	SURG	Kansas City

M.D. GRADUATES IN 1973

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Harris, W.L.	Overland PK	Baylor	Childrens Mercy KC,MO	PED	Independence,
Hartman, G.L.	Towanda	Southwestern	St. Lukes KC,MO	MED	Shawnee Mission
Hartman, H.A.	Lawrence	KU	Univ of Nebraska Omaha	MED	Omaha, NB
Hay, R.L.	Osawatomie	KSC-Pittsburg	St. Joseph Wichita	FP	Wichita
Heck, D.M.	Atchison	KSU	KUMC	FP	Claremore, OK
Helling, T.S.	Leawood	KU	St. Lukes KC,MO	MED	KC.MO
Heryer, J.W.	Shawnee Mission	KU	St. Lukes KC,MO	SURG	KC,MO
Higuchi, J.H.	Lawrence	KU	KUMC	MED	San Antonio TX
Hitchcock, C.T.	Overland PK	KU	KUMC	SURG	Shawnee Mission
Jacobson, M.S.	Lawrence	KU	KUMC	PED	Shawnee Mission
Jewell, M.L.	Shawnee Mission	Univ. of PA	L.A. Co. Torrance, CA	SURG	Manhattan Beach
Karnaze, D.Z.	Kansas City	Univ. of PA	USC Medical Center L.A. , CA	MED	Pasadena, CA
King, Kenneth R.	Glasco	Harvard	Univ. of TX San Antonio, TX	PSYC	San Antonio, TX
Kiser, R.E.	Overland PK	KSY	St. Lukes KC,MO	OB	Castle AFB, CA
Kittrel, G.H.	Shawnee	KU	KUMC	ANES	Denver, CO
Klassen, L.W.	Lehigh	Tobor Iowa City, IA	State Univ	MED	Bethesda, MD
Knecht, G.L.	Wichita	KU	KUMC	MED	Delmar, CA
LacKamp, R.J.	Hutchinson	WSU	St. Lukes KC,MO	ROT-MED	St. Louis, MO
Lee, W.H.	Topeka	KU	L.A.Co L.A. CA	OB	Englewood, CO
Leifer, W.N.	Shawnee Mission	Tulane	Grady Mem. Atlanta, GA	ROT-PATH	Atlanta, GA

M.D. GRADUATES IN 1973

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
Lemanski, A.J.	Pittsburg	KSC-Pittsburg	Madigan Gen. Tacoma, WA	OB	Tacoma, WA
Lerner, S.A.	Shawnee Mission	Indiana	KUMC	MED	Shawnee Mission
Lloyd, J.W.	Maple Hill	KU	Mercy Cedar Rapids, IA	FP	Concordia
Loveland, G.C.	Riley	KU	Childrens Mercy KC,MO	PED	Lawrence
MacArthur, R.J.	Overland PK	Nondegree	KUMC	SURG	Shawnee Mission
Marsh, G.E.	Eldorado	Ottawa	St. Lukes KC,MO	ROT	Kansas City
Maxwell, R.A.	Topeka	Washburn	Childrens Mercy KC,MO	PED	KC,MO
McDonald, L.V.	Deloit	Phillips	Univ of CA Los Angeles, CA	PED	Windber, PA
McNeal, D.M.	Topeka	KSU	Childrens Mercy KC,MO	PED	Whiteman AFB MO
Mertz, J.I.	Fort Scott	KU	St. Lukes KC,MO	MED	Shepard AFB, TX
Mooney, W.M.	Shawnee Mission	Iowa	Cleveland Clinic Cleveland, OH	ROT-MED	Cleveland, OH
Morning, D.E.	Clearwater	KU	St. Francis Wichita	ROT	Claremore, OK
Myers, A.I.	Mission Hills	Washington U	KUMC	PSYC	KC,MO
O'Boynick, P.L.	Kansas City	Nondegree	Parkland Dallas, TX	SURG	Kansas City
O'Bryan, J.J.	Prairie Village	Rockhurst	Univ of OK Oklahoma City, OK	PED	Shawnee Mission
Olsen, P.S.	Eldorado	KU	St. Lukes KC,MO	MED	Eldorado
Osborn, M.M.	Stockton	KU	Univ. of TX San Antonio, TX	MED	Pueblo, CO
Patterson, B.W.	Larned	KU	Mayaguez Med Ctr Puerto Rico	ROT	Ruerto Rico
Penny, E.A.	Garden City	KU	St. Anthony Denver, CO		Lakewood, CO
Peterson, J.D.	Shawnee Mission	KU	KUMC	PSYC	Kansas City

M.D. GRADUATES IN 1973

N	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT L ION
ace, K.C.	Shawnee Miss.	Univ of IL	St. Lukes KC, MO	SURG	KC, MO
Pro, J.D.	Leawood	KU	Swedish Seattle, WA	ROT	Nashville, TN
Railey, R.M.	Wichita	Univ of AR	Mercy Cedar Rapids, IA	FP	Cresco, IA
Raphel, J.E.	Larned	St. Marys-Plain	KUMC	PSYC	St. Joseph, MO
Rate, P.S.	Wichita	WSU	L.A. Co. Los Angeles, CA	ROT	Halstead
Rate, R.G.	Halstead	Occidental	L.A. Co. Los Angeles, CA	ROT	Halstead
Reding, M.J.	Wichita	ST. Benedicts	U.N. Omaha, NB	MED	Omaha, NB
Regier, L.M.	Moundridge	Bethel	Charity New Orleans, LA	ROT-MED	Colby
Robinson, D.B.	Leawood	KU	KUMC	OB	Topeka
Rocereto, P.V.	Topeka	Geneva	W. Pa. Pittsburg, PA	ROT	Topeka
Romito, C.L.	Liberal	Ottawa	KUMC	PED	Missoula, MT
Romito, J.A.	Overland PK	Cen Mo ST	St. Lukes KC, MO	SURG	Missoula, MT
Romondo, S.A.	Pittsburg	KSC-Pittsburg	KUMC	ANES	Olathe
Ross, W.R.	Leawood	KU	KUMC	MED	Shawnee Missio
Roulea, D.N.	Phillipsburg	KU	Tuscon Med Tuscon, AZ	ROT	Newton
Ryan, W.S.	Emporia	KU Phoeniz, AZ	Good Sam	PED	Emporia
Saylor, S.	Topeka	Northwestern	St. Lukes KC, MO	ROT-SURG	KC, MO
Sebree, S.G.	Salina	KU	KUMC	OB	Salina
Seibel, S.G.	Bonner Springs	Bethany	General KC, MO	SURG	Shawnee Missio
Simpson, T.C.	Wichita	Col of Emporia	St. Joseph Wichita	FP	Portsmouth, NH

M.D. GRADUATES IN 1973

NAME	HOMETOWN	B.S. DEGREE FROM	LOCATION OF RESIDENCY	RESIDENCY SPECIALTY	PRESENT LOCATION
[illegible]der, R.H.	Lincoln	KU	KUMC	ANES	Olathe
Snyder, T.E.	Arkansas City	KSU	KUMC	OB	Biloxi, MS
Swanson, H.J.	McPherson	Bethany	St. Lukes KC, MO	ROT	KC, MO
Swinney, R.S.	Bartlesville, OK	KU	L.A. Co. L.A., CA	MED	L.A. CA
Taylor, M.M.	Pittsburg	KSC-Pittsburg	L.A. Co. L.A., CA	SURG	L.A., CA
Terrill, L.A.	Topeka	KU	St. Lukes KC, MO	MED	Annandale, VA
Theel, J.E.	Fairway	Bethany	Swedish Seattle, WA	ROT	Seattle, WA
Thomas, G.M.	Lawrence	KU	Martin Ft. Benning, GA	FP	Fr. Benning, GA
VanGundy, M.J.	Salina	Ks Wesleyan	Mercy Cedar Rapids, IA	FP	Cedar Rapids, IA
VanSpeybroeck,J	Wichita	KU	U.M. Ann Arbor, MI	SURG	Oakland, CA
VanSpeybroeck,N	Leawood	Washington U	U.M. Ann Arbor, MI	MED	Oakland, CA
Watkins, P.H.	Shawnee Miss	KU	Presby Denver, CO	ROT	Richester, MN
Weber, R.R.	Independence	KU	St. Francis Wichita	MED	North Newton
Wertzberger, KL	Lawrence	KU	U.M. Minneapolis, MN	SURG	Rochester, MN
Wible, J.C.	Wichita	KU	Scott AFB IL		Shawnee Mission
Wood, B.C.	Wichita	KU	St. Lukes, KC,MO	MED	KC, MO
Wood, D.G.	Wichita	KU	KUMC	RAD	Shawnee Mission

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1977.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Albani, Frank	Oglesby, IL	St Louis Col of Pharm	Creighton Univ.	Surg	Liberty, MO
Amirsoleimani, M.	Babal, Iran		Pahlevi Med Sch	Psyc	Rochester, NY
Armstrong, Harold	Merriam	Baker Univ.	KU	Surg	Pittsburg
*Artzer, Dennis	Topeka	Washburn Univ	KU	Med	
Bare, Charles	Wichita	KU	KU	Surg	
*Beller, Thomas	Topeka	KU	KU	Med	Tuscon, AR
*Bidnick, Terrence	Kansas City	KU	KU	Surg	
Blessing, Larry	Bethany, MO	UM-Columbia	UM-Columbia	Med	Columbia, MO
Bodensteiner, David	Jackson-Junction, IA	Univ of Iowa	Univ of Iowa	Med	
*Brandsted, Mark	McPherson	KU	KU	Surg	
Breder, Hilke	Hamburg, Germany	Univ of Iowa	Univ of Iowa	Med	
*Bredfeldt, James	Kingsley	KU	KU	Med	Columbia, MO
Brown, Leon	Philadelphia, PA	State Univ of PA	State Univ of NY	Path	Univ. Hts, OH
Byrd, Richard	Ottawa	KU	KU	Med	
*Cannon, Jack	Pittsburg	KSC-Pittsburg	KU	Rad	
*Cannon, Michael	Wichita	WSU	KU	Path	
Carter, James	Fairview	Ottawa Univ	KU	Surg	
*Cathcart-Rake, Wm.	Fullerton, CA	Univ of Colo	KU	Med	
Chaleby, Kutaiba	Baghdad, Iraq		Univ of Baghdad	Psyc	
Cohn, Steven	Overland Park	UM-Columbia	KU	Anes	Kansas City

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INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 19 77.

NA	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT L. .TION
Coker, James E	Desoto	KU	KU	Med	
* Cossette, Jerrold	Mission	MU-Kansas City	KU	Surg	
Curran, Terrance	Kansas City,MO	Standford Univ	KU	Ophth	Kansas City, MO
Dahlie, James	Phillips,WI	Univ. of WI	Howard Univ	Rad	Jamestown, NY
Day, Howard	Kansas City	Bethany Coll	KU	Med	
* Deschner, William	Shawnee Mission	KU	KU	OB	Billings, MT
Deyarman, Kent	Cedar Rapids,IA	Univ. of Iowa	Univ. of Iowa	Ped	
Donnelly, F.Michael	Denver, CO	Regis College	KU	Anes	Kansas City
* Dunlap, John	Liberal	KSU	KU	Med	
Engrav, Loren	Decerah, IA	Univ. of CA-Davis	Univ of CA-LA	Surg	Seattle, WA
* Evans, Dan H.	Salina	KU	KU	Med	
Fast, Robert	Atchison	KU	KU	OB	Atchison
Fox, Deanna	Plainville	KU	KU	Anes	Kansas City
* Franklin, Benjamin	Kansas City	KU	KU	Med	
Freiden, Floyd	Omaha, NB		Univ. of Iowa	Surg	Kansas City,MO
Friesen, Dale	Prairie Village	Bethel Coll	KU	Anes	Lawrence
Fullard, Jasper	Wyens, GA	Tuskegee Inst	Univ of WI	Med	
Gilbert, John	Lawrence	KU	KU	Surg	Garden City
Ginsberg, Brent	Shawnee Mission	Princeton Univ	Columbia Univ	Med	
Goert , Kenneth	Shawnee Mission	Occidental Coll	KU	Ped	Kansas Cit

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1977.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
* Green, Elaine	Kansas City	KU	KU	Psyc	Washington, DC
Green, Louis	Kansas City,MO	KU	KU	Neuro	
* Grinstead, Dan	Bonner Springs	STU	KU	Med	Casper, WY
Guerin, Michael	Creighton,NB		Univ. of NB	Otor	Longview, WA
Hackman, Larry	Fulton, MO	Westminster	UM-KC Dentistry	Anes	Manhattan
Hansen, Frank	Shawnee Mission	KU	KU	Med	
* Harbin, Gary	Salina	KU	KU	Surg	
Hartje, James	Oakland, IA	Wartburg Coll	Univ. of Iowa	Med	
* Hauxwell, Jon	Stockton	KU	KU	FP	Lame Deer, MT
* Hill, Rodney	Wichita	Greenville Coll	KU	Med	
Hosler, James	Milwaukee, WI	Univ. of MI	Univ. of MI	Pharm	
Hutchison, Edward	Pittsburgh, PA	Univ. of PA	Temple Univ	Med	
* Jacobson, Marc	Prairie Village	KU	KU	Ped	
Jensen, Thomas M.	Wood River, NB	Kearney State Coll	Univ. of NB	Surg	Olathe
Jones, Cameron	Pittsburg	KU	KU	Med	
Kepes, Kathryn	Rock Island,IL	Univ. of IL	St. Louis Univ.	Med	
Kirby, Robert L	Arvada, CO	Univ of CO	UM	Med	
* Lauver, Mary Ann	Wichita	WSU	KU	Ped	Wichita
Legarda, Marcia	Manila, Phillipines	Univ. of Santo Tomas	Univ of Santo Tomas	Neur	Kansas City, MO
Lester, John B.	Oskaloosa	Washburn	KU	Psyc	Kansas City

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 19 77.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Lillich, David	Bradley, IL	Valparaiso Univ	Abraham Lincoln	FP	Topeka
* Loftus, Loretta	Kansas City	Tulane Univ	KU	Med	Rochester, NY
Lovett, Rodney	Neodesha	KU	KU	Surg	
Manahan, Antonio	Manila, Phillipines		Far Eastern Univ	Med	Kansas City
Mangum, William	Anna, IL	Memphis State Univ	Univ of TN	Otor	Kansas City, MO
Manion, William	Kansas City,MO	KU	KU	FP	
Marr, Garrett	Springfield,IL	Univ of KY	Univ of IL	Surg	KUMC
* Martinez, John	Hutchinson	KU	KU	Med	
* Maybury, Marsha	Kansas City	KU	KU	Ped	Detroit, MI
McCarthy, Vincent	Shawnee Mission	Seattle Univ	Univ of WA	Ped	
* McCusker, Kevin	Boulder, CO	Univ of ND	KU	Med	
McGuire, Thomas	Kansas City,MO	Univ of CA-Berkeley	Univ of CA-San Fran	Med	
McHugh, James	Tacoma, WA	St Martins Coll	Univ of WA	FP	
Middendorf, Donald	Cincinnati,OH	Xavier Univ	Ohio State Univ	Med	
Milligan, Donald	Baltimore, MD	Sterling Coll	John Hopkins Univ	FP	Olathe
Mohan, K. Jagan	Madras State India		Madras Univ of India	Neuro	St Paul, NM
Murphy, Jay W.	Canton, OH	Denison Univ	Ohio State Univ	Med	
Murray, Consuelo	Rio Vista, TX	Rice Univ	Univ of TX	Med	
Newcomer, John	Colorado Springs, CO	CO Coll	St Louis Univ	Med	
Ninchoji, Toshiaki	Chiba City Japan		Chiba Univ	Surg	Ontario, Canada

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1977.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Old, Jerry	Garden City	KU	KU	FP	Arkansas City
Olson, Thomas	Powers Lake, ND	Univ of ND	Northwestern	OB	Billings, MT
* Petelin, Joseph	Kansas City	Benedictine Coll	KU	Sur	Kansas City
Pollock, Allan S	New York, NY	State Univ of NY Buffalo	Albert Einstein Coll	Med	
* Preskorn, Sheldon	Roeland Park	WSU	KU	Psyc	St Louis, MO
Quiason, Emmeline	Philippines		Univ of Philippines	Psyc	Kansas City
Racela, Luz	Philippines		Univ of the Philippines	Path	
Reynard, James	Manhattan	KSU	KU	Path	
Roach, James	Jersey City, NJ	St Joseph Coll	Univ of Iowa	Med	
* Robinson, John	Wichita	KU	KU	Anes	Kansas City
Robinson, Michael	Pierre, S.D.	SD State Univ	Univ of NB	Med	
Rosenthal, Stanton	St Joseph, MO	KU	KU	Rad	Kansas City
* Ross, David K	Arkansas City	KU	KU	FP	Arkansas City
Sarno, E. Michael	Iowa City, IA	Johns Hopkins Univ	Univ of Iowa	Med	
Schaeferle, Martin	IA	Univ of Iowa	Univ of Iowa	Surg	Olympia, WA
* Schubert, A William	Great Bend	KU	KU	Ophth	Charleston, IL
* Sebree, Robert	Salina	KSU	KU	FP	Boise, ID
* Shockey, Mark	Abilene	KU	KU	Med	
Silver, Bradd	Fairfield, CT	Univ of NC	Emory Univ	Med	
* Silverberg, David	Overland Park	KU	KU	Med	

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BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 19 77.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Silverglat, Michael	Dallas, TX	KU	Ku -	Psyc	Kansas City
* Smith, David E	Liberal	Southwestern CA	KU	Surg	
* Smith, Stephen B	Larned	KU	KU	Med	
* Smith, Timothy	Wichita	KU	KU	Med	
Stehman, Frederick	Ann Harbor, MI	Univ of MI	Univ of MI	Surg	Los Angeles, CA
Steiner, Janice	Sydney Australia		Sydney Univ	Phar	Oxford, England
* Sturgeon, Janet	Hutchinson	KU	KU	Ped	
Sudhakar, Madakasira	Tirupati India		S.V. Medical Coll	Path	KUMC
Suiter, Daniel	Stafford	KU	KU	Med	
Sutherland, James	Bloomfield, KY	Vanderbilt Univ	Univ of KY	FP	
Taban, Hashem	Tehran Iran		Tehran Univ	Surg	
* Torrence, Michael	Overland Park	UM-Columbia	KU	Ped	Chester, PA
* Trombold, Walter	Wichita	KU	KU	Med	
Tropp, Arnold	Lenexa	UM-KC	KC College of Osteopathic Med	FP	Overland Park
Unger, James	San Gabriel, CA	San Fran State Coll	Univ of CA	Path	Olathe
Villalon, Joseph	Walsenburg, CO	Southern Colo State Coll	Stanford Univ	FP	Gallup, NM
Visser, Philip	Kirkwood, MO	Iowa State Univ	Univ of Iowa	Surg	
* Von Lintel, Thomas	Hayes	KU	KU	Anes	Topeka
* Wagner, Robert	Ellinwood	KU	KU	Med	
Wahl, Timothy	Omaha, NB	Univ of NB	Univ of NB	Med	

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1977 .

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LATIC
* Walker, Donald E	Shawnee Mission	KU	KU .	Psyc	Dayton, OH
Waters, Chester	Omaha, NB	Wabash Coll	Univ of NB	Surg	
* Waxman, Michael	Kansas City,MO	Coe Coll	KU	Med	
* Williamson, John	Prairie Village	Duke Univ	KU	Surg	KUMC
* Wilson, Mary	Wichita	Washington Univ	KU	Ped	
Wood, Gary	Wichita	KU	KU	Rad	Kansas City
Wulfsberg, Einar	Arlington,VA	Duke Univ	Med Coll of VA	Rad	

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1976 .

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Achar, Sudha	India		Bangalore Med Coll	PSY	Wilsonville, OR
* Adams, John S.	Overland Pk	KU	KU	MED	
Ahmad, Ijaz	Mission		King Edward Med Col	NEU	Rochester, MN
Baker, Steven	Denver, CO	Univ of Denver	Univ of CO	PSY	Kansas City
Bannow, John E.	Mt.Clemons,MN	Albian Coll	Univ of MI	SURG	St. Joseph, MI
Bartley, James A.	Powhattan	Emporia KS ST Col	Univ of IA	Pediatrics	KUMC
Bedard, Charles K.	Prairie Vil	AZ St Univ.	Univ of AZ	MED	Shawnee Mission
Belt, Robert J.	Denver, CO		Univ of CO	MED	KUMC
Bieri, Peter V.	Seneca	KU	KU	OTOR	Lawrence
* Bishop, Rodney	Shawnee Miss	KU	KU	MED	KUMC
Broky, Wayne	Blue Rapids	Sterling Coll	KU	REHAB MED	Phoenix, AZ
Burroughs, Nathan D.	Overland Pk	KSU	KU	OTOR	New Orleans, LA
* Burson, Marilyn	Mission	Ottawa Univ.	KU	REHAB MED	Liberty, MO
Clark, David P.	Denver, CO	Univ of CO	Univ. of CO	MED	
Clarke, Richard B.	Wichita	KU	KU	SURG	Amarillo, TX
Clemons, Charles	Chicago, IL		Univ of TX	PED	Spring, TX
* Code, William	Lisbon, ND	Jamestown Coll	Univ of ND	FP	Wellington, ND
* Cooper, Kent J.	Oswego	Rockhurst Col	KU	FP	Pittsburg
* Corder, Robert	Highland	KU	KU	OB	St. Joseph MO
* Cossette, Jerrold E.	Mission	Univ of MO	KU	MED	KUMC

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INTERNS AND RESIDENTS COMPLETING PROGRAM
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NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Cox, Ira L.	K.C., MO	Bethany Nazarene Coll	KU	DIAG RAD	KUMC
Craig, Charles C.	Newton	Bethel, Col	KU	SURG	Port Lee, VA
Cunningham, John	Liverpool Eng.		Liverpool Univ	CLIN PHARM	
Cunningham, Mary	Liverpool Eng.		Liverpool Univ	DIAG RAD	
* Day, Chester	Olathe	KU	KU	PSYC	Prairie Village
Dehkhargahani, F.	Kansas City		Meshedlin, Iran	PED	
Dillon, William	Burr Oak	KSU	KU	SURG	Anchorage, AK
* Dworzak, David	Coffeyville	WA Univ.	KU	MED	
Elmets, Craig	Polk, IA	Univ of IA	Univ of IA	MED	
Englebrake, Peggy	Kansas City	KU	KU	MED	Kansas City
Estes, Norman	Abilene	Bethany Coll	KU	SURG	Lexington, KY
* Fairchild, Richard	Kansas City	Washburn Univ	KU	MED	KUMC
Felt, Samuel	Wellington	WSU	KU	PATH	Wellington
* Ferguson, Robert	Overland Pk	KU	KU	MED	KUMC
Ferris, Bruce	Wichita	KU	KU	SURG	Wichita
* Florez, James P.	Kansas City	KU	KU	MED	Overland Park
Frayier, Richard	Wellington	KU	KU	SURG	Emporia
Goetzinger, Robert	Overland Pk		KU	OPTH	Marietta, GA
* Goldman, Barry	Shawnee Mission	Maiam Univ	KU	MED	KUMC
Good, James T.	Fort Scott	KU	KU	MED	Denver, CO

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BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1976.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
* Gorenz, David	Peoria, IL	Northwestern Univ	KU	MED	KUMC
* Gray, Captain King	Barnes, ND	ND ST Univ	KU	MED	KUMC
Guastello, Joseph	KC, MO	Univ of MO	Ortho		
Guthrey, B. Eugene	McCurtain, OK		Univ of OK	MED	
* Haire, Wiliam	Iola	KS ST COL of Pitts.	KU	MED	KUMC
Hara, Glenn	San Diego, CA	San Diego ST Univ	Univ of CA at LA	OB	Lenexa, KS
Hargis, James	Conway, AK	St Col of AK	Univ of AK	MED	Tulso, OK
Harris, Carolyn	Georgia	Dillard Univ	Howard Univ	PED	
Hart, Kelly Z.	Fort Scott	KS ST Col of Pitts	KU	MED	KUMC
* Heck, David	Atchison	KS ST Univ	KU	MED	Claremore, OK
* Higuchi, Junji	~~Lawrence~~ Madison, Wi	KU	KU	MED	San Antonio, TX
Hirakawa, Masahisa	Okayoma City	JA.	Okayma Univ	ANES	Japan
Hohern, David G.	Mason City, IA	Univ of IA	Univ of IA	SURG	Topeka
Hanicek, Gary	Morrill, NB	Univ of NB	Univ of NB	MED	Springfield, MO
Kabayaski, Masashi	Osaka, Japan		Oaska Univ	Endoc & MET	
Kammer, Robert	Johnson	OH ST Univ	Creighton, Univ	MED	Miami, FL
Kappel, David	New Martinsville, WV	WV Univ	WV Univ	SURG	
Kennedy, Timothy	Fairway	KU	KU	MED	Shawnee Mission
Khorasani, Ferangis	Iran		Univ of Tehran	PSYCH	Kansas City
Kittrel, Franklin	Mission	KU	KU	ANES	KUMC

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NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Klosterhoff, Bruce	Lenexa	Univ of IL	Univ of IL	MED	Leawood,
Lash, Ray Edward	Osawatomie	KU	KU	MED	
Leher, George	Illinois	Univ of Dayton	Univ of IL	PED	Fargo, ND
Lenty, Harold	Neosho, MO	Drury Coll	Univ of MO	SURG	Kansas City, M
* Li, Ulysses	Lawrence	Princeton Univ	KU	MED	Madison, WI
* Liesmann, Jean E.	Salina	KSU	KU	MED	KUMC
Low, Richard	Texas		Univ of NC	PED	Houston, TX
Martinez, Pedro	Madrid Spain		Madrid Med School	CLIN PHARM	
* Matthews, Earl H.	Trescott	KU	KU	SURG	
Mausbach, Thomas	S. Dakota	Augustana, Coll	Baylor	PED	Fargo, ND
Mills, George Q.	Overland Pk	Univ of NB	Creighton Univ	PATH	Wichita
Moritz, Ernest	Bucks, PA	Brown Univ	KU	MED	
Murphy, Jay W.	Canton OH	Bennison Univ	Ohio ST Univ	MED	
* Muther, Richard	KC, MO	KU	KU	MED	
Ondreyco, Sharon	Lorain Ohio	OH St Univ	OH ST Univ	MED	
Parsa, Cyrus	Los Angeles CA	CA ST Univ	KC COl of Osteo MED	PATH	Prairie Villag
Paterson, Michael	Larned	KU	KU	REHAB MED	Garden City
Pearson, Joanne	Shakopee, MN	Radcliff Coll	Univ of MN	PSYC	St. Paul, MN
Pekas, Wayne	Sioux Falls, SD	Univ of SD	KU	Opth	Sious Fal[illegible], S
Penka, Wayne	Larned	Plains Coll	Creighton Univ	Pathology	FPO Seattle, W

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NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Quiason, Arturo	KC, MO	Univ of Philippines	Univ of Philippines	PSYC	Kansas CIty, M
Quaison, Emmeline	KC, MO	Univ of Philippines	Univ of Philippines	PSYC	KUMC
* Ricci, Robert L.	Lenexa	KU	KU	MED	KUMC
* Richards, Dallas	Atwood	KSU	KU	MED	KUMC
* Robinson, David B.	Overland Pk	KU	KU	OB	Topeka
Rodriquez, Raul	Bagota Colombia	NTL COL of SAN	Bartalome NTL U of Columbia	PSYCH	
* Ramondo, Steven A.	Pittsburg	KS ST COl of Pitts.	KU	ANES	Olathe
* Ross, Walter	Overland Pk	KU	KU	MED	
Sashika, Tatsuro	Tokyo Japan		Tolyo MED Coll	OB	
Schroeder, David	Mansfield, OH	Univ of NC	OH St Univ	MED	
Schuety, Perry	Great Bend	KU	KU	OPTH	Ft. Lee, VA
* Sebree, Steven	Salina	KU	KU	OB	Salina
Snyder, Richard	Kansas City	KU	KU	ANES	
Stout, Carl	Kansas City	Baker Univ	Univ of MO	OPTH	Olathe
* Stuewe, Bradley	Lawrence	KU	KU	MED	Kansas CIty
Suiter, Daniel	Stafford	KU	KU	MED	KUMC
* Taylor, Sarah	Wichita	Cornell	KU	MED	Shawnee
Toyama, Masagki	Japan		Keio Univ	SURG	
Uetrecht, Jack	Butter, OH	Univ of Cin.	OH ST Univ	MED	
Vaseenon, Thammium	Thiland		Chiangamai Univ	PED	KUMC

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NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Verdirame, Joseph	Syracuse, NY	LeMayne Coll	ST Univ of NY	MED	
* Wait, Juliette	Mission	KU	KU	MED	
Walbriam, John	NB	Univ of NB	Univ of NB	PED	
* Warren, Donald O.	LaHarse	KU	KU	SURG	
Watson, Rick	Columbus, OH	Denison Univ	OH ST Univ	MED	
Weare, Mary E.	Burns, OR	Lewis & Clark COL	Univ of OR	Psy	Prairie Villag
Whitaker, James A.	Atchison	KU	KU	MED	KUMC
* Wilhelm, Donald	Shawnee Miss	Duke Univ	KU	MED	Rochester, MN
Williams, Sterling B.	Jackson, MO	Univ of IL	Univ of AK	OB	Lenexa
Wilson, Michael	West Columbia,TX	Rice Univ	Univ of TX Southwestern	DIAG RAD	Davenport, IA

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BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 19 75.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Allen, James E.	Shawnee Mission	KU	KU	MED	Hays
Battamer, Robert E.	KC, MO	Cent MO State	Univ of MO	OB	KC, MO
* Baxter, William R.	Salina	Standard Univ	KU	FP	Salina
Blessing, Larry D.	Bethany, MO	Univ of MO	Univ of MO	MED	
Bliss, Morton	Excelsion Springs MO	Jamestown Coll	Univ of NE	ANES	
Blumber, Morton	Baltimore, MD	Univ of MD	Univ of MD	DIRA	Miami, FL
Bogart, Douglas	Shawnee Mission	KU	KU	MED	Shawnee Mission
Barel, David	Shawnee Mission	KU	KU	PATH	Andrews AFB, MD
Brandwine, Warren	Southfield, MI	MI State Univ	Chicago Coll of Osteopathic Med	OB	Woorhees, NJ
* Bredfelt, James E.	Abilene	KU	KU	MED	Columbia, MO
* Cathcart-Pake, William	KC	Univ of CO	KU	MED	Kansas City
Chang, Ho-Huang	Taichung, Taiuan		Karshiung Med Coll	PATH	Kansas City
Cho, Sechin	Korea		Seoul Nat. Univ.	PATH	Baltimore, MD
Coe, John B.	Chicago	Unif of OK	Univ of OK	FP	Coalgate, OK
Coker, James E.	Dewitt, AR	KU	KU	MED	Shawnee Mission
Cranston, Stephen D.	Winfield,	KU	KU	SURG	Nellis AFB, NV
* Day, Howard A.	KC	Bethany Col	KU	MED	Kansas City
Dickerson, Shelby	Roanoke, VA	Univ of Richmond	Univ of VA	MED	
Dodson, Leonard	Harding, OK	KU	KU	MED	APO New York
Doll, David A.	Lincoln	KU	KU	ANES	Lander, WY

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INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1975 .

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Dorzal, William E.	Kansas City	KU	KU	PATH	Armed Forces-Germa
Eakins, Kent R.	Paxton NB	Midland, Coll	Univ of NB	OTOR	KUMC
Eggleston, Richard	Wichita	Univ of Dayton	KU	OPTH	Spokane, WA
Eikermann, William	Los Angeles, CA	KSTC	KU	PYCH	KC, MO
Emo, John W.	Sedalia, MO	Rockhurst Coll	St. Louis Univ	FP	Cedar City, UT
Engstrom, Ervin,	Prairie Village	Coll of Wooster	OH St. Univ	MED	
* Ervin, John	Kansas City	Notre Dame Univ	KU	MED	KC, MO
Fahrenholtz, Daniel	Sylvia	Sterling Col	KU	FAPR	Kingman, KS
Farran, William	Arkansas City	KU	KU	MED	Arkansas City, KS
Fixley, Mark	Osawatomie	KU	KU	MED	Shawnee Mission
Fullard, Jasper	Jefferson, GA	Tuskegee, Inst.	Univ of WI	MED	
Galoof, Harry D	Healdton, OK	Univ of OK	Univ of OK	OTOR	Belleville, IL
Good, James T.	Wichita	KU	KU	MED	Denver, CO
Gower, Rowland E.	Nashville, TN	TN Tech Univ	Vanderbelt Univ	SURG	Elmendorf, AK
* Grinstead, Dan	Bonner Springs	KSU	KU	MED	Kansas City
Harris, Susan K.	Ellsworth	KU	KU	MED	Kansas City
Hartje, James L.	Oakland, IA	Wartburg Coll	Univ of IA	MED	
Haskey, Robert S.	KC, MO	Rockhurst Coll	KU	SURG	Mt. Home, ID
Hawkins, Doris J.	Grandview		Univ of MO	PYCH	KC, MO
Headlee, Thomas	Searcy, AR	Univ of AR	Univ of AR	MED	Tucson, AZ

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 19 75 .

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Hill, James G.	East Chester,NY	Univ of NM	KU	PYCH	Tucson, AZ
* Hill, Rodney W.	Mission	Greenville Col	KU	MED	Shawnee Mission
Hirsch, Martin	Overland Park	KSTC	KU	PYCH	Overland Park
Hodes, Herbert	Shawnee Mission	Univ of MO	KU	OB	Hutchinson
Hoffman, Lee M.	Glen Ridge, NJ	Standard Univ	Univ of CA	NEUR	Shawnee Mission
Hosler, James	Kansas City	Univ of MI	Univ of MI	MED	
Howard, William R.	Arkansas City	OK State Univ	KU	OTOR	Arkansas City
Hunter, William	Sagramento, CA	Gonyaga Univ	Creighton Univ	PATH	KUMC
Jacoby, Robert E.	Topeka	Johns Hopkins Univ	Johns Hopkins Univ	FP	Topeka, KS
Kamath, Vasant	Bonbay, India		Wadia Childrens Hosp.	PED	
Kennedy, Timothy	Kansas City	KU	KU	DIRA	Shawnee Mission
Khoo, Boon Heck	Malaysi		Univ of Malaya	PED	Ipoh, Malaysia
Kiser, Charles	Ft. Hayes	KU	KU	DIRA	Malnstrom, Montay
King, Charles	Manhattan	KSU	KU	OB	Ft. Lewis, WA
Kugler, Kenyon	Phillipines	KSU	KU	SURG	Tulsa, OK
Lanier, Robert	Lenexa	Univ of CO	Univ of CO	MED	
LaSalle, Anthony	KC, MO	Univ of MO	Univ of MO	ANES	
Lin, Joe	Taiwan, China	NTL Taiwan Univ	Taipei Med Coll	PATH	Wichita
* Loftus, Loretta	Shawnee Mission	Tulane Univ	KU	MED	Shawnee Mission
Long, John Warren	Lane	Ottawa Univ	KU	SURG	Topeka

INTERNS AND RESIDENTS COMPLETING PROGRAM
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NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Lopez Francisco	Equador	Military Aca Equador	Central Univ	ANES	
Ma, Frank	Wichita	Univ of AR	Univ of AR	MED	KC, MO
Mabie, Bill C.	Parsons	KU	KU	MED	Los Angeles CA
Maddux, Bill D.	Wichita	KU	KU	MED	Kansas CIty
Mausbach, Thomas	Cnaton, SD	Univ of SD	Bayoln Coll	PED	Fargo, ND
Mavris, Michael	Fort Lauderdale		Univ of Athens	FP	Cresent City, CA
McCanse, Lynn R.	KC, MO	Dartmouth Univ	MO Univ	SURG	KC, MO
McGuire, Thomas	KC, MO	Univ of CA at SF	Univ of CA at SF	MED	Prairie Village
McNeal, Jerry	Prairie Village	Beloit Univ	KU	PED	
Middendorf, Donald	Cincinnati, OH	Xavier Univ	OH St Univ	MED	
Mijares, Carlos	Caracus Venezuela	Fermin Toro Coll	Central Univ	PED	
Millett, Ruth	Gromwich, CT	Park Coll	KU	PATH	KUMC
Miner, Michael	Lawrence	KU	KU	SURG	Houston, TX
Moddrell, Carol	Shawnee Mission	KU	KU	PATH	Lawrence
Mockton, Laurence	Leawood	KU	KU	SURG	Shawnee Mission
Moore, Jack Dean	Dallas, TX	KSU	Univ of MO	SURG	Kansas CIty
Murphy, Everett M.	Tulsa, OK	Ok St Univ	Univ of OK	MED	
Nyquist, Steven R.	Wichita	WSU	KU	PATH	KUMC
Pardo, Lillian	Philippines		Univ of Philippines	PED	KUMC
Pearson, Jeanne	Shakepee, MN	Radcliffe, IL	Univ of MN	PYCH	St. Paul, M.

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NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
* Preskorn, Sheldon	Wichita	WSU	KU	PATH	St. Louis, MO
* Ransom, Kenneth Kenneth		KU	KU	SURG	KC, MO
Reilly, Douglas Douglas	Idaho Falls, ID	Univ of ID	Univ of NB	MED	Kansas City, MO
Roach, James J.		St. Joseph Coll	Univ of IA	MED	
Robinson, James E.	Hermansville	KU	KU	DIRA	Green Bay, WI
Roeloso, Dan	Denver, CO	Univ of CO	Univ of MO	ANES	KUMC
* Rosen, David	Prairie Village	Northwestern Univ	KU	PED	Shawnee Mission
Rosett, Walter	Atlantic City, NJ	Johns Hopkins Univ	Mt. Sinai Sch of Med	MED	
Ruhlen, James	Baldwin, AK	Wesleyan Univ	KU	MED	Shawnee Mission
Rumans, Garry	Shawnee Mission	Ottawa Univ	KU	MED	Sunnyvale, CA
Sales, Harvey	Pittsburg, PA	Univ of MI	Univ of Pittsburg	NEUR	Tacloma, WA
Schwegler, Robert	KC, MO	DePaue Univ	KU	DIRA	Ft Leonard Wd, MO
* Sifers, Timothy	Shawnee Mission	KU	KU	SURG	Shawnee Mission
Smith, Kirk M.	Little Rock, AK		Univ of AK	SURG	Ft. Collins, CO
* Smith, Stephen B.	Larned	KU	KU	MED	Shawnee Mission
Spicer, Thomas	Rock Springs	Univ of WY	Univ of WA	MED	
Stauffer, Larry	Jefferson City, MO	Westminister Coll	KU	OPTH	Jefferson City, MO
Stearns, Frederick	Manhattan	KSU	KU	SURG	Oxnard, CA
Stehman, Frederick	Overland Park	Univ of MI	Univ of MI	OB	Overland Pa
* Tatlock, Thomas	Wichita	KU	KU	MED	Madison, WI

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BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1975.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATIO
* Trombold, Walter	Wichita	KU	KU	MED	Shawnee Mission
* Ulrich, Brian	Topeka	Creighton Univ	KU	MED	APO NY
Wahl, Timothy	Omaha, NB	Univ of NB	Univ of NB	MED	
Walker, Tany	Wichita	KSU	KU	DIRA	
Walters, Daniel	Dallas, TX	Univ of OK	Univ of OK	MED	Palms Marie Base
Wei Chen-Tzu	Hiroshima, Japan		Tokyo Woman's Med Coll	PATH	
Weinstein, Charles	Shawnee Mission	KU	KU	MEUR	Kansas City, MO
Wennen, William	Virginia, MN	Univ of MN	Univ of KY	SURG	
Whitaker, James A.	Atchison	KU	KU	MED	Shawnee Mission
Whitaker, James H.	KC, MO	Univ of MO	Univ of MO	SURG	KUMC
Wilcox, Howard	Lawrence	KU	KU	SURG	Hays, KS
Wissing, Joel Alan	Chicago, IL	Northwestern Univ	Univ of AL	DIRA	

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BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1974.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Ahmed, Anwar	India	Non-Degree	Osmania, India	Path	
Apfelberg, David	Milwawkee, WI	KU	Northwestern	Surg	Palto Alto, CA
Arazi, Richard	Leavenworth, Wi	Il	U of Il	Neur	St Louis Park, MN
* Barnes, James	Arkansas City	KU	KU	Med	Norfolk, VA
Bedard, Charles	Phoenix, AZ	AZ ST.	U of AZ	Med	
* Boggan, Michael	Charleston, SC	U of GA	Med. Col. of GA	Surg	Shawnee Mission
Bolton, Merle	Biloxi, MO	KU	KU	CV	Palm Springs, CA
Brian, William	Elderodo	WSU	KU	Anes	Spring Field, MO
Carley, James	Tulsa, OK	Westminster	U of OK	Med	Ormand Beach, FL
Cecil, John	St. Louis, MO	Westminster	Baylor	Rad	Hays
Chang, Kuo	Taiwan,	Non-Degree	Nat. Taiwan U.	Ped	Wichita
Cole, James	Hutchinson	KU	KU	Med	Ft. Benning, GA
Compton, Alan	Wilmington, CA	UCLA	UC-SF	Med	Army-mail Shawnee Mission
Conrad, Kenneth	Redding, PA	Albright	U of PA	Med	Philadelphia, PA
* Dworzack, David	Coffeyville	Wash U.	KU	Med	Shawnee Mission
Edmond-Englebrake	Kansas City	KU	KU	Med	Kansas City
Elberg Alfredo	Chile	Non-Degree	Chile Med School	Ped	Kalamazoo, MI
Emmott, William	Independence	KU	KU	Med	Independence
* Ferguson, Robert	Prairie Village	KU	KU	Med	KUMC
Fischer, William	San Diego, CA	SD St. Col.	U of CA	Ped	

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NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
*Florez, James	Rosedale	KU	KU	Med	Shawnee Mission
Flury, Kirk	Shawnee Mission	KU	KU	Med	Augusta, GA
Foss, Daniel	Great Bend	KU	KU	Med	Hutchinson
Franks, Darrell	Glasco	KU	KU	Psyc	Louisville, KY
Freeman, Frederick	Rosedale	KU	KU	Urol	Manhattan
Freeman, James	Plattsburg, MO	KU	UM - Columbia	Med	Columbia, MO
Glaser, Larry	Hutchinson	KU	KU	Surg	Kansas City, MO
Gray, Roberta	Chapel Hill, NC	KU	U of NC	Ped	
Griffin, Samsoi	Bankok, Thailand	Chulalongoon U	Siriray	psyc	
Groves, Robert	Chatonooga, TN	Emory	U of TN	Surg	
Hahn, Bruce	Kansas City	Wash U.	Baylor	Surg	
*Haight, John	Jockson, MO	KU	KU	Surg	KUMC
Harris, Lanny	Union City, MO	KU	U of TN	Surg	Kansas City, MO
Hartong, William	Euroka	W.S.U.	KU	Med	Augusta, GA
Hasting, Charles	Kansas City	KU	John Hopkins	Med	
Hatton, Donald	Salina	KU	KU	Med	Lawrence
Hedeman, Lynn	Lansing MI	MI State	U of MI	Surg	Ada, MI
Hiesterman, Dwight	Linn	KU	KU	Med	Helena, MT
*Higuchi, Junji	Lawrence	KU	KU	Med	San Antonio, TX
*Hitchcock, C. Thomas		KU	KU	Surg	Shawnee Mis

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1974 .

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Hodes, Herbert	Prarie Village	U of MO	KU	OB	Hutchinson
Hoffman, Jerry	Lakin	KU	KU	Psyc	Ceiba, P.R.
Hunninghake, Gary	Kelly	St. Benedicts	KU	Med	Rockville, MD
Hunt, Thomas	Southwest, Mo	U of MO	KU	Med	Smithville, MO
*Jacobson, Marc	None	KU	KU	Ped	Shawnee Mission
James, David	Tulsa, OK	MI State	KC Col. of Ost.	Med	Tulsa, OK
Jensen, Thomas	Hall Co. NB	Kearney State	U of NB	Surg	Olathe
Kanner, Robert	N.Y. NY	Ohio U	Creighton	Med	Miami, FL
Kanner Steven	Canton OH	KU	OH U	Med	
Kappel, David	Wetzel WV	KU	WV Univ.	Surg	
Kittrell, Franklin	Osawatomie	KU	KU	Anes	Denver, CO
* Knecht, Gregory	Wichita	KU	KU	Med	Del Mar, CA
Krueger, Alan	Shawnee Mission	Baker	KU	Psyc	KUMC
Laird, Dale	Rochester, NY.	Bethany	KU	Opth	Olathe
Lampton, Lawrence	K.C. MO	Rockhurt	U of MO	Med	Indianapolis, IN
* Lerner, Scott	Overland Park	U of IN	KU	Med	Shawnee Mission
Leung, Patrick	Hong Kong	Non-Degree	U of Hong Kong	Ped	
Levin, Joel	Philadelphia,PA	Non-Degree	U of FL	Surg	South Miami, FL
* MacArthur, Richard	Overland Park	KU	KU	Surg	Shawnee Mission
Mattingly, Larry	Leroy	KSU	KS Col. of Ost.	Med	Overland Pa

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1974 .

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Mc Donald, Robert	Crown Pt. IN	Non-Degree	U of IO	Med	Madison, WI
MC Dougal Barbara	Abernathy, TX	KU	U of NM	Med	Chickasha, OK
Mc Guire, Michael	Artesia, NM	Abilene Chr.	KU	Med	Mission
Melchior, Jerome	Topeka	Ku	KU	Urol	Vincennes, IN
Milligan, Donald	Nampa, ID	Col of ID	KU	Psyc	Olathe
Moyer, Ronald	South Bend, IN	KU	Ind, U	Ped	Louisville, KY
Murphy, Barry	Lincoln	KU	KU	Med	Wichita
Neighbor, Ernest	Culver Acad. IN	KU	KU	Surg	Pittsburg
New, Norman	Red Field, SD	Northern State	U of TX	OB	Nellis A.F.B. NV
Newton, Charles	Grain Field	KU	KU	Med	Portland, OR
Parikh, Aruma	India	Non-Degree	Gujarat, India	Path	
Peckler, Scott	Chicago, IL	Non-Degree	Loyola	Surg	
Perry, Carmel	Colorado Sp. CO	KU	U of CO	Med	Colorado Springs,C
Rea, John	Little Rock, AR	KU	U of AR	Rad	Lafayette, LA
Rinkenberger, Robert	Shawnee Mission	KSU	KU	Med	Fort Campbell, KY
Rivera, Michele	Detroit, MI	KU	Wayne State	Path	
Roller, James	Hannibal, MO	KU	U of MO	Med	Columbia, MO
Rollins, Douglas	Lodi, OH	OH state	U of UT	Med	Silver Springs, MD
* Romito, Cynthia	Liberal	Ottawa U	KU	Ped	Missoula, MT
* Romondo, Steven	Pittsburg	KSC-Pittsburg	KU	Anes	Olathe

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1974.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Romeiser, Rex	Selina	KU	KU	Urol	Salina
* Ross, Walter	Prairie Village	KU	KU	Med	Shawnee Mission
Schroeder, David	Mansfield, OH	U of NC	OH state	Med	
Segura, Roberto	Valencia,Spain	Spain	U of Valencia	Med	New York, NY
* Snyder, Richard	Lincoln	KU	KU	Anes	Olathe
Stephens, Doyle	Terre Houte, IN	KU	IN U	Med	Muncie, IN
Weiss, Stephen	Cleveland, OH	Wash. & Jeff.	OH state	Med	Cleveland, OH
Williams, Clyde	Shawnee Mission	KU	KU	Med	Santa Monica, CA
Wilson Stewart	Leavenworth, MO	KU	KU	Opth	Roseburg, OR
Wolfe, John	Conway Springs	Southwestern	KU	Med	Hutchinson

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1973.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Allen, James	Shawnee Miss	KU	KU	MED	Hays
Allen, Joseph	Kansas City,MO	KU	Marquette	PSYC	Kansas City
Anderson, Donald	Wichita	WSU	KU	ANES	Wichita
Baker, Larry	Pen Yan, NY	Wooster	Creighton	MED	Kansas City
Baumeister, Jacqueline	Waukee, IA	KU	IOWA	PSYC	Terrell, TX
Bergmann, Stephen	St. Paul, MN	Univ of Minn	KU	PED	Rancho Palos C
Burroughs, Nathan	Manhattan	KSU	KU	SURG	New Orleans, LA
Braden, Roy	Chanute	Baker	KU	NEUR	Casper, WY
Carter, Robert	Tonkawa, OK	nondegree	Univ. of OK	OB	Kansas City
Chua, Franco	Philippines	nondegree	Cabu Inst of Med	PED	Marshalltown,IA
Clarke, Richard	Wichita	KU	KU	SURG	Amarillo, TX
Cohlmia, Jerry	Wichita	WSU	KU	MED	Wichita
Conrad, Joseph	Chillicothe,	Notre Dame	St. Louis Univ	MED	Salt Lake City,
Conrad, Kenneth	Reading, PA	Albright	KU	MED	Philadelphia, P
Cooper, Barry	Norton	KU	KU	RAD	Kansas City
Cooper, Robert	Lafayette, KY	Duke	KU	MED	Kansas City
Crabb, Winston	Billings, MT	KU	Northwestern	OB	Lincoln, NE
Craft, Phil	Hugo, OK	ME State Col	Univ of OK	SURG	Chattonooga, TN
Cudnik, Daniel	Cathedral Latin, OH	John Carroll Un.	Marquette	SURG	
Cusack, Thomas	Peoria, IL	Notre Dame	Univ of IL	RAD	Peoria, IL

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 1973.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Darr, Richard	Basin, WY	Univ of WY	New Mexico	MED	Lake Quivira,
Diaz-Y-Barriga, Fernando	Mexico City	Centro Univ Mex	Mexico	SURG	Minneapolis, MN
Dickerson, Shelby	Roanoke, VA	Univ of Richmond	KU KU	MED MED	Kansas City APO New York
Dodson, L. Edwin	Oklahoma City, OK	KU	KU	MED	APO New York
Doll, David	Lincoln	KU	KU	ROT	
Draper, Edward	Indep., MO	Graceland	KU	PSYC	Sandpbignt, ID
Duff, Wallace	Omaha, NB	Univ of NB	Univ of NB	OTOR	Omaha, NB
Elberg, Alfredo	Santiago,Chile	nondegree	Chile Med School	PED	Kalamonso, MI
Elliott, Jeffrey	Harrisburg, PA.	Duke	KU	ROT	
Faraon, Jose	Philippines	nondegree	Univ of Philippine	PATH	
Farney, Robert	Kansas City,MO	KU	KU	MED	Salt Lake City,
Felt, Samuel	Wellington	WSU	KU	PATH	Wellington
Fixley, Mark	Osawatomie	KU	KU	MED	Kansas CIty
Fouts, Terry	Shawnee Miss	KU	KU	RAD	Pueblo, CO
Gilford, Christopher	Omaha, NB	nondegree	Creighton	PED	
Glending, David	Topeka	KSU	KU	ROT	Topeka
Glenn, James	Protection	Southwestern	Baylor	SURG	Emporia
Gnaw, Frederick	Bethal, KS	Park Coll	KU	OTOR	Halstead
Goheen, John	Independence	KU	KU	MED	Kansas Cit
Goldware, Stephen	Omaha, NB	KU	Rulane	NEURO	Lafayette, LA

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 19 73.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATIO
Good, James	Fort Scott	KU	KU	MED	Denver, CO
Goodwin, John	Edna	Univ of AK	KU	ROT	Kansas City
Grady, Kenneth	Manual,MO	Park Col	KU	PSYC	Shawnee Missi
Gray Roberta	Chapel Hill,NC	KU	Univ of NC	PED	
Guerra, Jeorge	Miami, FL	KU	Univ of Miami	ROT	Miami, FL
Gwin, Edward	Ada, OK	EC State Col	Univ of OK	MED	Springfield,
Haas, Charles	Argentine	Yankton	KU	MED	Kansas City,
Harwood, Theodore	Grand Forks,ND	KU	Univ of VT	MED	Duluth, MN
Harris, Susan	Wilson	KU	KU	MED	Kansas City
Headles, Susan	Kansas City	KU	KU	MED	Kansas City,
Hellman, Richard	New York, NY	NYU	Chicago	MED	Kansas City,
Henry, Joseph	Bushton	KSC-Emporia	KU	MED	Kansas City,
Hiller, Frederick	Humboldt	KU	KU	MED	Little Rock,
Hiszczynskyi, Roman	Ft. Dodge,IA	Univ of MN	Univ of IA	PATH	Kansas City
Hoherz, David	Mason City,IA	KU	Univ of IA	SURG	Topeka
Hunkler, John	Kansas City,MO	Harvard	KU	OPTH	kansas CIty,
Humminghake, Gary	Kelly	St. Benedicts	KU	MED	Rockville, MD
Hurwitz, Judith	Cleveland, OH	KU	Case Western	PSYC	Kansas City
Kaler, Ronnie	Paducak, KY	Murray St.	Vanderbilt	SURG	Ft. Wor TX
Kavel, Karl	Williamsburg PA	Univ of Pittsburg	Bowman Gray	PED	Topeka

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 19 73.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Korb, Thomas	Milwaukee, WI	Notre Dame	Marquette	MED	
Lees, Joyce	Citronelle, AL	KU	Univ of AL	SURG	
Levene, Alan	NY, NY	KU	Johns Hopkins	ROT	Topeka
Lynch, Joseph	Phila, PA	St. Joseph's	Temple	MED	San Francisco,
Mabie, Billy	Parsons	KU	KU	MED	
Maddux, Bill	Wichita	KU	KU	MED	Monroe, WI
Mahoney, James	Jonesboro, TN	KU	KU	SURG	Johnson City, T
McDougal, Barbara	Abernathy,TX	KU	Univ of New Mexico	MED	Chickasha, OK
McKeel, Thomas	Pine Bluff, AR	Fisk	Univ of AK	MED	Kansas City
Merritt, Thurman	Wichita	KU	KU	PED	
Milligan, Donald	Manpa,ID	Col. of ID	KU	PSYC	Kansas City
Montes, Idalina	Puerto Rico	KU	Univ of Puerto Rico	PED	Puerto Rico
Morgan, W. Richard	Sherman,TX	KU	Univ of OK	SURG	Kansas City
Moyer, Ronald	South Bend,IN	KU	Indiana Univ	PED	Louisville, KY
Nieva, Delfin	Phillpines	KU	Philippines	ANES	
Nashida, Taskashi	Nagoya,Japan	nondegree	Nagoya City Univ	NEUR	
Orr, William	Peabody, TN	Stanford	Tulane	ROT	Albuquerque, NM
Osterholm, O. Douglas	Lincoln, NB	KU	Univ of MB	RAD	Omaha, NB
Oxler, John	Kansas City MO	Rockhurst	KU	MED	Wichita
Pecoraro, Anthony	Rochester,NY	KU	Rochester	PED	Shawnee Mission

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 19 73.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Pelletier, Lawrence	Meadville, PA	Bowdoin CO	Columbia	MED	Hargo, ND
Penka, Wayne	Larned	St. Marys-Plains	Creighton	PATH	FPO Seattle, WA
Peterson, James	Oven, CO	KU	Univ of NB	OTOR	
Rater, David	Ottumwa, IA	St. Ambrose	Univ of IA	MED	Cedar Rapids, IA
Rauscher, Clifford	St Louis, MO	KU	Univ of MO	MED	
Reynard, James	Manhattan	KSU	KU	MED	Kansas City
Richards, Robert	Fort Morgan,CO	KU	Univ of CO	URO	Idaho Falls, ID
Roach, Neil	Macksville	OK State Univ	KU	PSYC	Halstead,
Ruhlen, James	Corpus Christi TX	Wesleman	KU	ROT	Shawnee Mission
Rumans, Larry	Shawnee Miss.	Ottawa	KU	MED	Sunnyvale, CA
Sietz, Elson	Hutchinson	KSU	KU	PATH	Indep., MO
Sethi, Amarjit	India	nondegree	All India Inst.	PED	Shawnee Mission
Shriner H.C.	Hastings NB	KU	Univ of NB	PED	
Silverglat, Michael	Jefferson, TX	KU	KU	PED	Kansas City
Skibba, Richard	Kaukauna, WI	KU	Marquette	MED	Wichita
Smith, Dale	Omaha, NB	KU	Creighton	Ped	Shawnee Mission
Stopple, John	Ferguson,MO	Grinnell	Univ of WI	OB	Olathe
Stoskope, Larry	Hoisington	KSU	KU	ROT	Wichita
Stuber, Jack	St Joseph, MO	KU	KU	RAD	Shawnee Mi[illegible]n
Terhune, J. Nicholas	Murray, KY	Murray ST.	Vanderbilt	MED	

INTERNS AND RESIDENTS COMPLETING PROGRAM
BETWEEN JULY 1 OF PRIOR YEAR TO JUNE 30, 19 73.

NAME	HOMETOWN	B.S. DEGREE FROM	MD DEGREE FROM	SPECIALTY	PRESENT LOCATION
Underwood, Johnson	KC, MO	Wm. Jwewll	Univ of MO	SURG	Kansas City, MO
Vachanasvasti, Vilaivain	Vankok, Thiland	nondegree	Thiland	ANES	
Vaughan, Donna	Smith Center	KU	KU	PSYC	Newton
Vergara, Gerardo	Isabella, Phil	KU	Univ of Santo Tomas	PATH	Shawnee Mission
Walters, Daniel	Dallas, TX	KU	Univ of OK	MED	Palms Marine, C
Warner, Richard	Lawrence	KU	KU	MED	
Weaver, Walter	Augusta	KSU	KU	OPTH	Topeka
Wennen, William	Virginia, MN	Univ of MN	Univ of KY	SURG	
Whitaker, James	Norton	KU	KU	MED	Kansas City
Wiegman, Hugh	Des Moines, IA	Iowa ST	Univ of IA	RAD	
Yates, Darrel	Buffalo, MO	SW MO ST	UM-Columbia	RAD	St. Louis, MO
Yeomans, Ronald	Fayette, MO	CM&ST	KU	OB	Overland Park

E

The Admissions Process at the University of Kansas School of Medicine

Goals

The primary goal of the University of Kansas School of Medicine is to educate doctors for Kansas. To achieve this goal, students are provided a medical curriculum and clinical training of the highest possible quality. Additionally, students are given a balanced, flexible, educational experience so that they will be able to choose intelligently among the large variety of careers that exist in the field of medicine. In its role as a state-supported institution, the KU School of Medicine has set these goals to best serve the multi-faceted needs of the public for physician manpower--in primary care, in the sub-specialties, and in health-related teaching and research.

Qualifications of Applicants

In selecting students the School of Medicine recognizes that the demand for intellectual ability, maturity and sensitivity is as great for a career in primary care as it is in research. The School also recognizes that a wide variety of backgrounds and education will produce applicants with these qualities and with a diversity of interests in medical careers.

Medicine is both a scientific and social discipline so the School requires that each student have a solid science education, possess the ability to communicate effectively and show promise of developing into a mature, sensitive person who will inspire and deserve trust and confidence.

Qualified students who are residents of the state of Kansas are admitted first, after which highly qualified candidates from other states are given consideration. The 200 places in the entering class are always offered first to the top 200 Kansas applicants. Decisions on each applicant are made without regard to race, color, sex, marital status, or creed. Members of disadvantaged or minority ethnic groups and individuals who are physicially handicapped are encouraged to apply.

The Selection Process

When the proper credentials have been received, applicants are selected for an interview with the members of the Selection Panel. The selection is made on the basis of the applicant's academic record, Medical College Admission Test Scores and other factors. Normally the number of applicants interviewed is twice the number of openings available. Any Kansan who has not been selected for an interview may request one.

All applicants are interviewed for approximately an hour by a team composed of:

one basic science faculty member;
one clinical faculty member;
one non-physician selected by the Governor of Kansas; and
one practicing physician from the state of Kansas.

The team does not see the student's academic credentials until the interview is completed. The interview is not intended or designed to be a stressful situation. Questions from the interview panel attempt to determine the following type of information:

interpersonal rapport;
maturity of thought and perception;
intellectual honesty;
community involvement, donation of time to others;
use of non-academic time;
development of skills related to medical science;
motivation for the study of medicine; and
a realistic self-appraisal.

Following the interview, each member of the team ranks the applicant -- 1 (high), 2, 3 or unsatisfactory--on the basis of his or her potential for successful completion of the medical curriculum and potential success as a physician. At the end of each day's interviews, the team reviews the academic record, MCAT scores and premedical advisor's report of each student and then determines its recommendation to the full Selection Panel. The Selection Panel considers and votes on the recommendations of each day. Decisions on those not recommended are held until all the interviews are concluded. The Selection Panel then meets to consider all the pending applications and completes its list of recommendations.

The recommendations of the Selection Panel are later acted upon by the Admissions subcommittee of the Academic Committee, then by the Academic Committee which submits a list of recommended applicants to the Executive Vice-Chancellor. Final decisions are determined administratively.

F

Testimony by the Kansas Department of
Health and Environment

to the

Special Committee on Ways and Means

regarding

Proposal #69

July 7, 1977

Presented by Joseph F. Harkins

Thank you for the opportunity to present the position of the Kansas Department of Health and Environment on the problem of a physician shortage in Kansas.

The shortage of primary care medical services in Kansas is severe in rural areas when the lack of a physician often translates to no medical services at all. The problem is also intensified in rural areas because 45% of the elderly in Kansas, the people most in need of easily available medical care, live in these areas.

In 1955-56, there were nearly 7,000 medical school graduates in the United States, and in twenty years this had almost doubled to 13,000. In 1955, the Kansas University Medical Center graduated approximately 100 medical students. By 1980, nearly 200 students will graduate annually. In 1953, there were 2,327 physicians in Kansas. In 1973, there were 2,566, but this increase was almost totally offset by population growth. Thus, Kansas has not enjoyed a significant gain in physicians despite the large overall increase in supply.

If the ratio of one primary care physician per 1,000 population is a good standard, only 16 of our 105 counties in Kansas are adequately covered and the actual shortage of such physicians exceeds 700. The FBPR (Florida Baseline Physician Ratio), which is accepted as a national standard,

requires 80 primary care physicians per 100,000 persons. The present Kansas ratio is 53/100,000. To meet FBPR standards in 1980, 1,228 additional physicians will be needed in the state.

Some have assumed in the past that increasing the number of medical student graduates at the University of Kansas Medical Center will solve the shortage of physicians in the state. However, these new graduates feed into the national pool and our success in tapping this supply has been very poor. Recruitment, then, must be geared to physicians at or near the end of their specialty training and directed to medical students and practicing physicians all over the United States.

The lack of past success in recruiting physicians and dentists in Kansas leads to the following conclusions:

1. A recruitment program centered on Kansas graduates and/or trainees from the University of Kansas Medical Center is too limited in scope. Recruitment should be conducted on a nationwide basis.
2. Recruitment activities should be geographically based in the areas of the state where the shortage is most acute, and not located in the state's largest urban setting.
3. Successful recruitment must involve brokering between communities and professionals, and must be directed to reach professionals scattered across the nation in an organized and efficient way.
4. The successful recruitment broker needs:

a. intimate knowledge of the geographic area he is serving;

b. intimate knowledge of community leadership;

c. intimate knowledge of community and area needs; and

d. sufficient resources for travel and entertainment of recruits.

5. A number of communities in the state have been unsuccessful in recruiting physicians and dentists because they have not utilized the recruitment services which are available. By and large, national placement services, nationwide advertising, and a computerized approach to recruiting have not been tried in Kansas.

The Department of Health and Environment and the University of Kansas have planned a joint program to expand recruitment efforts in Kansas. The 1977 Legislature provided $37,000 to initiate this effort and an application is now pending to the Ozarks Regional Commission for an additional $72,500. Major emphasis will be placed on a nationwide health provider recruitment program but it will be closely allied with the emerging health care delivery system of this state.

The program will require the cooperative efforts of the Department of Health and Environment, the University of Kansas Medical Center, the Department of Economic Development, local communities, hospitals, and physicians. Basic to the activity from the beginning will be community organization and involvement spearheaded by recruiters based in the

community but closely linked with computerized manpower data informatio which will serve to bring communities and prospects together.

Community recruiters will be located in four of the six district offices of the State Department of Health and Environment. These will be Hays, Dodge City, Chanute, and Topeka. The recruiters will serve in a brokerage capacity between communities and prospects, and will carry out community education programs in an effort to develop realistic expectations toward the health care delivery system and will explore, with community leaders, alternative ways of delivering primary health care.

Every small Kansas community cannot have a physician. The competitive approach where every Kansas community irrespective of size, resources, or viability has built medical facilities and attempted to recruit and retain physicians has caused financial loss, frustration, and disillusionment to these communities. There has been no concerted program in the state to work with them in an effort to develop alternative methods of health care and to create more realistic expectations of what level of health care they can expect and can support.

The following story reprinted from ACTION PLAN, a publication of the American Medical Association, illustrates this problem eloquently.

> Six months after opening his practice in a rural midwestern community of 650, Doctor X packed his bags and returned to his former practice in a large city. Now disillusioned, Doctor X and the townspeople are asking themselves, "What went wrong and why?" Initially excited about leaving the city for a small-town practice, Doctor X says the community is lovely and the people friendly--but that it was an experiment that just didn't work. Besides some unfulfilled promises which the town's leaders had made, Doctor X believes the citizenry had no idea

of what a physician's needs are. "They demanded to know where I was every minute of the day. I found that folks who wouldn't come in for an office appointment never hesitated to ask me to make housecalls round-the-clock for every routine problem. Their expectations were simply unrealistic," he says. "Although the town wanted a physician of their own, patients had become accustomed to traveling to other communities within a ten-mile radius for medical care. Because they were reluctant to break their existing physician relationships, they didn't really need or use my services--except in emergency cases," he says.

The solution for this town and many like it, Doctor X feels, is not another doctor. "Very simply," he says, "They can't support one. It would be a better idea for them to work out a part-time clinic arrangement with another area physician, use a nurse clinician, or to have a special transportation service between their town and the hospital and medical offices which are 12 miles away."

Community leaders still maintain their town needs and can support a physician and they have begun a new recruitment campaign. They say they can't understand Doctor X's feelings and attribute them to the fact that he came from a metropolitan area. Disregarding his comments about their lack of cooperation and utilization of his services, they say there is no need to offer a guaranteed minimum income or any other special incentives, nor are they interested in developing alternative health care delivery programs. They contend that somewhere there is a physician who will open a practice in their community simply because he likes them and their community.

Summary

We feel the supply problem of physicians in the United States has essentially been resolved in terms of absolute numbers. The major problem in this state is (a) that we need to get a greater share of the national supply, and (b) we need to have more equitable distribution throughout the state. We feel these objectives can be realized without severe legislative remedies, especially when the impact of new health

professionals (Nurse Practitioners and Physicians' Assistants) is taken into account. The Legislature made another step toward providing specially trained nurse practitioners with its appropriation to the K. U. Medical Center for a special training program at Hays beginning next September. This new program (along with the two nurse practitioner programs and one physicians' assistant program already in place) should further alleviate the manpower shortage problem in the near future.

Work is underway to develop a combined community education/ recruitment program. While government agencies are actively involved there is much that must be done by community leaders and physicians themselves. We think the physician problem can be resolved on a voluntary basis in five years provided the physicians in this state agree to join efforts with the program I have outlined here. In the final analysis, most new physicians are going to be recruited by physicians now practicing in Kansas. We think quotas can be set for recruitment based upon geographic districts used by the Kansas Medical Society for organizational purposes. If physicians in those districts would then become active in the organized recruitment program, the problem can be resolved.

We propose that the Legislature set a two to three year time frame to observe the results. If we don't show substantial improvement in that time, then perhaps legislative intervention will be necessary.

OSTEOPATHIC LOAN FUND
Administered by
THE KANSAS BOARD OF REGENTS

SELECTION CRITERIA

The intent of the Legislature of Kansas in funding this loan program is to encourage students of osteopathic medicine from Kansas to return to this state to practice. Applications for assistance, therefore, should only be filed by Kansans when that is the applicant's intent.

Other factors which may be considered in the selection of students to receive loans and the amount which they shall receive include, but are not limited to, the following:

a.) Relative financial need among applicants.

b.) Academic rank in class, cumulative grade point average and/or MCAT scores.

c.) Length of time before being available to begin practice.

d.) Willingness to practice primary care medicine in the State of Kansas.

e.) Proportion of the total represented by minority applicants.

REPAYMENT OR FORGIVENESS

Loans shall be collectible under specific terms of the notes to be signed by recipients when they receive the money. General policy, however, will include the following:

a.) Repayment - Loans shall become due and payable, including the annual rate of 6% interest, if the student withdraws or is dismissed prior to completion of an academic year, does not practice in Kansas within six months after completion of training or fails to complete one year of service in Kansas for each year a loan was received.

b.) Forgiveness - Loans shall be forgiven if the recipient enters family practice in Kansas within six months after completion of internship or family practice residency program and completes one full year of practice for each year the student was a loan recipient.

COMMITMENT

I hereby attest that I am a bona fide resident of the State of Kansas and agree that if I am selected as a loan recipient for the study of osteopathic medicine, I will engage in the practice of osteopathic medicine in Kansas within six months of completion of my internship or family practice residency training program for the period of time required by contract. I further agree to a full investigation of my eligibility, including inquiries of business and professional persons and a release of my academic and financial records necessary in support of this application.

_____ _____

Name (Please Print) Signature

_____ _____

Address Date

_____

City State Zip

. . . . . WHEN and HOW to APPLY . . . . .

Applicants must submit a completed MEDISERVE application to the project coordinator by October 15 to be considered as a candidate for medical school admission the following summer. This application will require the recommendation of the local Medical Society and the County Farm Bureau.

MEDISERVE applicants must be applicants in good standing with the University of Kansas School of Medicine (the required American Medical College Application Service forms must be properly completed, the Medical College Admissions Test completed, etc).

The Admissions and Loan Board of MEDISERVE will conduct an annual interveiw session for all eligible MEDISERVE applicants. Applicants qualifying for the interview will be notified by November 15 of eligibility and time of interview.

FOR FURTHER INFORMATION, please contact: MEDISERVE Project Coordinator . . . 2321 Anderson Avenue . . . Manhattan, KS 66502

H

Kansas Medical Service
MEDISERVE
Project, Inc.

PURPOSE OF MEDISERVE . . .

This project has been established by the Kansas Farm Bureau and the Kansas Medical Society to strengthen opportunities for medical education and service in Kansas by:

(1) Helping qualified applicants meet the admissions standards of the University of Kansas School of Medicine, and

(2) Providing financial aid, when needed, to those students who are committed to the purposes of MEDISERVE.

MEDISERVE

A PROJECT FOR ALL OF KANSAS . . . . .

. . . STRENGTHENED MEDICAL EDUCATION OPPORTUNITIES

. . . FINANCIAL AID FOR COMMITTED STUDENTS

. . . MEDICAL PRACTITIONERS FOR RURAL AND UNDERSERVED AREAS OF KANSAS

Kansas Medical Service
MEDISERVE
Project, Inc.

KANSAS MEDICAL SERVICE PROJECT, INC. . . . MEDISERVE

General Information

Recommendation Assistance: The MEDISERVE Admissions and Loan Committee will annually recommend candidates for admission to the University of Kansas School of Medicine. After making proper application to UKSM, completing the Medical College Admissions Test (MCAT), and submitting the proper college transcripts, the applicant will be asked to complete a MEDISERVE Application. Qualifying applicants will be personally screened to determine which MEDISERVE applicants will be recommended for admission.

Loan Assistance: Students seeking financial aid will be contacted after they have been accepted by the University of Kansas School of Medicine. The UKSM Office of Student Affairs will provide a financial aid request form to be completed and returned for the consideration of the MEDISERVE Admissions and Loan Committee. This information will remain confidential and will offer a basis for selection of students to receive loan assistance.

Loans of $750 per semester--full tuition loans--are available during the four years of medical school ($6,000 maximum loan from this program). The total amount of loan funds available will vary from year to year, depending on the repayments into the revolving fund. Loans are granted at 4% interest. The borrower must insure her- or himself for the total amount of the intended loan and must pay the premiums on the policy. The repayment schedule of the principal amount begins January 1 of the fourth year following medical school graduation.

Eligibility Requirements: MEDISERVE applicants will be considered on a comparative and competitive basis regardless of whether they seek a recommendation, a loan, or both. The review policies of the Admissions and Loan Fund Committee will prohibit discrimination because of sex, race, color, religion, age, national origin, handicap, political or religious belief. Applicants must have the recommendation of the local Medical Society and the County Farm Bureau, as provided in the Application Form. MEDISERVE applicants must be Kansas residents. All MEDISERVE applicants must have completed all requirements for admission to UKSM.

Obligation: In return for assistance from the Kansas Medical Service Project, Inc., an applicant must agree to practice medicine in a rural or underserved area of Kansas. Practice time requirements will be as follows:

(1) Students receiving an admission recommendation only . . 5 years;

(2) Students granted loan assistance only . . one year of practice for each year that financial aid is awarded (one year minimum).

MEDISERVE participants may select a practice location with a demonstrated physician shortage. That practice location must be reviewed and approved by the MEDISERVE Admissions and Loan Fund Committee. The purpose of this project and a participant's signed agreement is to provide physicians for the rural and underserved areas of Kansas.

1977-2

DESCRIPTION of the KANSAS MEDICAL SERVICE PROJECT, INC.

. . . . . MEDISERVE

Philosophy

This project--a cooperative effort of the Kansas Farm Bureau and Kansas Medical Society--is based on the theory that certain students are, by virtue of background and experience, especially motivated and suited for rural medical practice. MEDISERVE will attempt to identify and help such students by acting as a provider-consumer advisory body to make recommendations to the Admissions Committee of the University of Kansas School of Medicine and also by offering financial support if needed. It is an attempt to provide physicians for the rural and underserved areas of the state. MEDISERVE does not believe that physicians can be bought or indentured and will not encourage project applicants who would consider the project in this light. It is anticipated that 20 applicants will annually receive the admission recommendation of MEDISERVE.

Recruitment

Applicants will be formally recommended for the project by an appropriate county Farm Bureau and local medical society. In addition to these sponsoring organizations, college pre-med advisors and former MEDISERVE participants will become contacts as the project develops. Project information will be made available at all state universities and may be requested by mail (Kansas Medical Service Project, Inc., 2321 Anderson Avenue, Manhattan, KS 66502).

Application Procedure

The application form requires that applicants first obtain the recommendation of the local Medical Society and the County Farm Bureau. Applicants must have had three years of college training ... have completed formal application for admission to the Kansas University School of Medicine and have completed the Medical College Admissions Test (MCAT). It will be a distinct advantage for any interested applicant to begin this process during the first semester of the fourth year of collegiate study in order to be an applicant in good standing--first with the Medical School and then with MEDISERVE. Admission applications must be received in the MEDISERVE office by October 15. . . . Students already admitted to medical school may apply for loans at any time during any year of their medical training. . . . Applicants must be residents of Kansas to be eligible for the MEDISERVE project.

Selection Procedure for Recommendation to the University of Kansas School of Medicine

Preliminary screening of MEDISERVE applicants will be made with representatives of the University of Kansas Medical School's Admissions Committee at which time some applications may be disqualified on the basis of low MCAT scores or low grades. The remaining applicants will be interviewed by the MEDISERVE Admissions and Loan Committee prior to the official interview session at UKSM. The MEDISERVE interview will be conducted

to evaluate the applicants from the standpoint of suitability and motivation for practice in an underserved area of Kansas. The success or failure of MEDISERVE is considered to hinge on this critical process. Applicants will be interviewed by the Admissions and Loan Committee--a screening panel made up of three representatives each from the sponsoring organizations. MEDISERVE interviews will be conducted in late November. Representatives of the UKSM Admissions Committee will be present during the MEDISERVE screening process and may ask questions but will have no vote. After each interview, each member of the Admissions and Loan Committee will rank the applicant with a score from 1 to 4--1 being the highest--and the collective scores will be totaled. The result will be a sequential list ranking MEDISERVE applicants according to the Committee's estimate of suitability for the project. Some applicants may be eliminated from the list if the Committee feels that applicants are not suited for the Project. . . . The list and rankings will then be submitted to the Admissions Committee of the University of Kansas School of Medicine. The UKSM Admissions Committee will evaluate the MEDISERVE applicants along with all other UKSM applicants during the late-December interview sessions. The University of Kansas will notify the Committee when acceptances have been made and simultaneous notices will be given to the applicants of acceptance or rejection, by the Admissions and Loan Committee of MEDISERVE and the University of Kansas.

Loan Applications

Students who are accepted into medical school either through the above procedure or without recommendation may apply for loans. This is done with the cooperation of the Office of Student Affairs of the School of Medicine and requires the filling out of a financial statement. Loans are given on a need-priority basis depending upon availability of funds at the time. Loans of $750 per semester (maximum) are available for the four years of medical school. Loans are granted at 4% interest. The borrower must insure him- or herself for the total amount of the intended loan naming the Kansas Medical Service Project, Inc. as the assignee of the policy and must pay the premium on the policy. This is not a forgiveness-type loan. Repayment on the principal does not begin until January first of the fourth year following graduation from medical school. All loan payments are payable to the Kansas Medical Service Project, Inc.

Obligations

Any student receiving an admission recommendation from MEDISERVE will agree to practice for five years in an underserved area of Kansas. Students requesting loan assistance only will be obligated for one year of practice for each year that financial aid is given. The selection of a practice location will be made by the MEDISERVE participant subject to the approval of the Admissions and Loan Committee. Students will be encouraged to take post-graduate training in primary care health specialties. Contracts will be used and liquidated damages will be specified for defection.

Follow-Up

An annual dinner meeting will be held in the Wichita and Kansas City area for MEDISERVE participants and alumni. An attempt will be made to maintain personal contact with the participants. Local Farm Bureaus and Medical Societies will play a key role in follow-up activities. Students will be required to keep the Board informed of plans for post-graduate education, military commitments, or any actions requiring a change of address.

Future Plans

The long pay-back delay and low interest rate make the revolving fund of MEDISERVE somewhat inadequate to meet all needs. It is anticipated that additional organizations, communities and individuals will be involved if this project is to expand to meet the goal of better developing medical service teams to meet the needs of rural and underserved Kansas communities. The program is geared to serve all of Kansas and we solicit the support and participation of all Kansans.

Kansas Medical Service

MEDI SERVE

Project, Inc.

APPLICATION FORM

(All applications must be postmarked by October 15)

Please check one:

Interested in admissions recommendation only _____

Interested only in loan _____

Interested in both admissions recommendation and loan _____

1. Name _____

2. Current Address _____

3. Home Address _____

4. Current Telephone _____ Home Telephone _____

5. Single _____ Married _____ Number and ages of children _____

   If married, list spouse's name and occupation _____

   If married, list spouse's home address _____

6. Height _____ Weight _____ State of health _____

7. Date of birth _____ Place of birth _____

8. Is your father living? _____ His occupation _____

   Is your mother living? _____ Her occupation _____

   Parents' names _____ Telephone _____

   Parents' address _____

9. How many brothers? _____ Ages (Circle those married) _____

   How many sisters? _____ Ages (Circle those married) _____

10. High School attended _____ Grade Average _____

    Graduation date _____ Major subjects _____

    Colleges attended (Include years) _____ Grade Average _____

    _____ Grade Average _____

    _____ Grade Average _____

**** Please enclose a transcript of your college work with this application.****

11. Have you taken the Medical College Admissions Test? _____

    If so, where? _____ When? _____

12. Have you completed your formal application for admission to the University of Kansas School of Medicine? _____ Is this your first application for admission? _____ If no, please explain previous admission attempt(s) _____

13. Have you met the Admissions Committee of any medical school? _____

14. Have you been accepted at any medical school? _____

Please explain a "Yes" answer to Questions 13 or 14: _____

15. Will you sign an agreement to establish a practice of medicine in an underserved area of Kansas serving rural people . . . this practice location to be approved by the MEDISERVE Admissions and Loan Fund Board . . . such practice to be maintained for a period of years as specified in the agreement for a maximum of five years? _____

(Students granted loans are expected to repay their loan amount and interest at 4% per annum during the above mentioned years of practice.)

16. How did you learn of this project? _____

17. Why do you want to become a doctor of medicine? _____

18. If you desire, you may submit two or three letters of personal recommendation and any other information that you may wish to offer concerning your activities, interests and motivations to help the MEDISERVE Admissions and Loan Fund Board become better acquainted with you.

RECOMMENDATION SECTION

PLEASE NOTE: The following signatures must be secured before this application is complete.

STATEMENT OF _____ Farm Bureau:

_____, President
Personal Signature

STATEMENT OF _____ Medical Society

_____, President
Personal Signature

_____

Please attach a photo of yourself.

_____
Applicant's Signature

_____

_____
Date of Application

I

Al Tikwart, Jr.
2109 W. 49th Street
Westwood Hills, Kansas 66205
(913) 432-0304

REPLY TO
ATTN. OF: Kansas Legislature

SUBJECT: Health Care Crisis in Kansas

PROBLEM:

1. How can Kansas improve its health care delivery system at a price that is affordable to the taxpayer and users of the system; yet, have as little state intervention into the system as possible?

FACTORS BEARING ON THE PROBLEM:

2. Is there a problem?

   a. Two Kansas counties do not have a doctor in residence and 10 others have only one physician. (Attachment #1)

   b. Six counties out of 105 meet suggested national health care standards. (Attachment #1)

   c. There are many areas in our state where there is one physician for 5,000 people, when the national average is about one physician for 650.

   d. Doctors' fees drain Blue Shield reserve to three days. (Attachment #2)

   e. Kansas Blue Cross has 1.4 months of claims and operating expenses in reserve. Projections show that reserves will not be above the 2.0 months reserve range for 1976. (Attachment #3)

   f. Doctors' costs have increased 50% faster than the economy as a whole-1974. (Attachment #4)

   g. Physicians' fees surged 3-4 times greater than all other services-1975. (Attachment #5)

   h. Prices of some services quoted by physicians are the same in our cities and towns and even the same on a county and state level. This inability to have meaningful price differences best shows how small the supply of doctors really is in our state.

FACTS: How is the leadership handling this crisis?

i. Study shows Blue Cross hesitant to control costs. (Attachment #6)

j. Medical Alumni of KU contribute $10-30 per year/graduate to their medical school.

k. Doctors in Metro Kansas City gave $35.46 as an average gift to the United Fund. Also, only 33.6% gave. Working men in the 25 largest Kansas City companies gave $40.26 per capita. (Attachment #7)

l. Board of Regents raised medical tuition at KU from $750 to $1125 per (1500 academic year 1976. This is the first tuition increase in five years.

m. The Association of American Medical Colleges in-depth survey suggests that it costs from $16,000 to $26,000 a year for the medical education of an American doctor--1973. (Attachment #8)

3. Assumptions

a. The legislative process is open to new ideas, and the hold of the AMA and Health Insurance Lobbies are not strong enough to stifle full discussion of the issues.

b. The proposed change should work in the free enterprise system to achieve its objective.

c. The proposed change should be one that looks at the intermediate to long range solution of the problem.

d. Under the present system, the majority of the burden has fallen on taxpayers and users of the system.

e. Medicine today is not in the free enterprise system.

4. Criteria

a. 1970 Demographic Yearbook of the United Nations.

b. 1971 Statistical Yearbook of the United Nations.

c. The Journal of the Kansas Medical Society, August 1975.

DISCUSSION

5. In 1972, Americans were spending 8.5% of their personal income on personal health services. This compares with 6.5% in 1962 and only 5.1% in 1951. In 29 years, health costs have increased five-fold. It would seem that Americans would be getting better care and more of it; but, compared to other developed countries, we are the lowest.

   a. Infant Mortality--the US ranks 15 out of 15.
   b. Male Life Expectancy--at birth US ranks 27 out of 31.
   c. Female Life Expectancy--at birth US ranks 12 out of 25.

6. The average office visit to a doctor's office, which takes 5-15 minutes of the doctor's time, costs $10-$25. It takes 6.09 hours of net work for a $10,400 a year person to pay for his visit. For a man making $20,800, it takes almost 3 hours. Yet, for a person making $100,000 it only takes 38 minutes.

   If a person is hit with a $5,000 non-covered doctor bill, then the $15 visit now takes 3-1/2 days of net work for the person earning $10,400/year. The person earning $20,800 now takes 1/2 day; while the $100,000 person takes only 1 more minute of work or 39 minutes to pay a $15 visit. (Attachment #9)

7. Present leadership such as Blue Cross Blue Shield is based on a cost-plus basis and is, as every businessman knows, "A partnership with the devil." When a certain percentage of doctors raise their fees, this new level then becomes the customary fee and BC and BS then pays out at a higher rate. This cost-plus system shows no regard for the true supply-demand situation.

8. According to a 1973 study by the Association of American Medical Colleges, it takes $64,000 to $104,000 to educate a doctor for four years. At the present rate of $750/year, it costs a Kansas medical student $3,000 for four years of schooling. The taxpayer picks up the majority of the $61,000 to $101,000 deficit per medical student.

9. All medical students pay only a small portion of their actual education costs. Kansas medical students pay even less than other medical students in the area. Kansas students pay $750/year while other medical students in the area pay $5,500-$7,000/year.

10. The financial rewards of being a doctor places the doctor in the top 1% of all income earners. The AMA, which certainly has no incentive to overstate doctors' incomes, reports that in 1970 the average practicing physician grossed $88,000 a year and netted $50,000. But doctors' fees have risen 10% or more a year since then. So $100,000 and $200,000 net plus practitioners are far from rare. (Attachment #10)

CONCLUSIONS

11. A solution to the high cost of a service or product would be to increase the supply in order to meet the demand. Presently, there are not enough physicians in Kansas to meet the demand. Only when there is some type of demand/supply equality can costs be brought in line with other free enterprise businesses.

12. Kansas needs to increase the number of physician graduates, especially general practitioners. Presently, the taxpayers of Kansas are paying more than their share--$55 million operating expenses for KU/year and also the taxpayers are financing a $70 million expansion of KU. The added cost of educating more doctors has to come from another source. Since physicians benefit by being in the top percentage of income earners, and since they are presently only giving $10-30/year to their university, they should rightly pick up more of the burden of their education costs. By having the physicians do it themselves, by contributing to a living endowment fund, we can bring medicine back into the free enterprise system.

13. The total number of living graduates of the KU Medical School is about 4,000. Of this amount, 2330 or 58% live outside the state of Kansas or the Metro Kansas City area.

ACTIONS RECOMMENDED

14. Tuition to the University of Kansas Medical School should be raised from $750/year to $20,000/year.

15. A living endowment should be set up to take these repayments and recycle them back into educating more doctors. Present state-born costs of running the medical school could be allocated to this living endowment fund.

16. Liberal repayments out of the living endowment fund of loans for tuition should be established.

    An example of such a repayment schedule could be:

    a. Area of Greatest Need

        (1) Counties that have 2 or less physicians.

        (2) Counties where patient to physician ratio is greater than 3,000 to 1.

        (3) Any area where physicians' full-time practice gross is less than $40,000/year. This would most likely include physicians electing a career in public health, teaching or public research.

            This group would be allowed the maximum forgiveness of $20,000/year for 4 years.

ACTIONS RECOMMENDED - (Continued)

b. Area of Secondary Need

(1) Counties that have between 2-10 physicians.

(2) Counties where patient to physician ratio is greater than 1,000 to 1 but less than 3,000 to 1.

(3) Any area where the physicians full-time practice gross is less than $45,000/year.

This group would receive $13,333/year in forgiveness for 6 years.

c. Area of Tertiary Need

Physician has to be a resident of Kansas or be a resident of a neighboring state and have his main office (50% or more of patients treated) in Kansas.

Forgiveness of $8,000/year for 10 years.

d. Non-Resident Physician Graduates

Physicians practicing outside of Kansas would be required to pay back to the endowment fund from which they borrowed at the rate of $20,000/year until their debt is paid.

(Repayment to the fund of service or cash would start for all who borrowed from the fund after the first six months a physician is working. If a physician would elect to take post graduate training, he would be allowed an extension not to exceed 4 years for such training before personal service or cash payments would be required as outlined above. Also, in order to encourage more family physicians, a special bonus of allowing 2 times the normal forgiveness amounts for those practicing in family medicine could be given.)

17. The above liberal repayment program would be administered by the Board of Regents in conjunction with the State Health Service Agency under the explicit guidelines set down by the Kansas Legislature.

18. Along with educating more doctors with the funds generated by this living endowment concept, extra dollars could now be allocated for Satellite Physician training programs in Wichita, Great Bend, Hays, etc.

Respectfully submitted,

Al W. Tikwart, Jr.

AL W. TIKWART, JR.

(10 Attachments)

ATTACHMENT 1

Governor Ill, Cancels Medical Center Speech

Gov Robert F. Bennett failed to make a scheduled speech today on health care at the University of Kansas Medical Center. The reason: he was ill.

Dr. Archie R. Dykes, university chancellor, told several hundred persons attending an open house at the medical center that Bennett was unable to attend because of a respiratory infection.

Aides said the governor had returned to Topeka last night from a speaking engagement in Ulysses, Kan., feeling worse froma cold that had been bothering him for a week.

Bennett's brief address waould have been one of the first talks of the event to acquaint representatives of Kansas communities with the medical center's attempts to meet state health needs.

"Here in Kansas are many problems in health care that we here at the University of Kansas Medical Center are trying to solve," Dykes said.

One of the chief complaints of Kansas residents, he said, is too many graduates of the medical center do not return to rural parts of the state to practice medicine.

Two Kansas counties do not have a doctor in residence and 10 others only have one physician, Dykes noted. He added only six counties meet suggested national health care standards.

"Indeed, many of our doctors don't want to live in small towns," Dykes said. Another problem cited was not enough general practice doctors.

He said, however, more medical students are going into primary care fields such as family medicine, general surgery or general pediatrics. He also said he detected increased interest by medical students in moving to smaller communities.

One basic step to increase the number of doctors in the western part of Kansas already has been undertaken, said Dr. Jack Walker, chairman of the Department of Family Practice at the medical center.

The first-year class this year is 200, he said, compared to 120 in 1970. "This means we have dramatically increased the physician's pipeline here at the medical center."

That growth will mean more doctors for smaller communities, he said.

(THE *Morning* KANSAS CITY STAR)

The Kansas City Times

MAIN EDITION ★ ★ KANSAS CITY, WEDNESDAY, SEPTEMBER 17, 1975 — 96 PAGES

Want Ads, 221-6000—Circulation, 221-6200
Sports, 471-3821—News, Business Office, 421-1200

Doctors' Fees Drain Blue Shield Reserve

By Phillip S. Brimble
Science-Medical Editor

The rise in physician fees, which has resulted in an unanticipated drain on the Kansas City Blue Shield cash reserve, apparently is a result of doctors passing on their increased malpractice insurance premiums to patients.

Missouri state law requires a 2-month reserve be maintained. By July, however, the Blue Shield account had dwindled to a 3-day reserve.

When the federal Economic Stabilization Program ended its price freeze in April 1974, physicians began to increase their fees at a rate, which, averaged for a year, amounted to 14 per cent.

That was anticipated by Blue Shield, which assumed the fee increases would quickly level off, and raised its premium schedule accordingly.

But the increase in physician fees didn't level off. The fees continued to climb at the 14 per cent rate during the first half of this year. Blue Shield, which raises its rates only once a year for each policy or contract holder, found itself in the financially unhealthy position of paying money out at a rate faster than it was taking it in.

To rebuild the reserve, the Blue Shield board of directors has initiated several procedures not only to curb the rise in doctor fees but to improve the board's ability to predict how quickly fees will rise and how much the health plan will be expected to pay physicians.

Physicians who accept the Blue Shield fee payment schedule—and that accounts for 90 per cent of all physicians in 30 Missouri counties and Johnson and Wyandotte in Kansas—were notified of the fee-control efforts in a letter dated Sept. 12 and signed by Dr. Earl C. Sifers, a surgeon and chairman of the health plan's board of directors.

"Please, make every effort to 'hold the line' on your fees," wrote Dr. Sifers.

"Although Kansas City area physicians generally acted with restraint in increasing their fees after April 1974, Blue Shield was locked into rates negotiated during the Economic Stablization Program well into 1975," he wrote.

"...what Blue Shield and physicians could not and did not expect was another significant round of fee increases during the first half of 1975, perhaps due in part to received or expected changes in malpractice premiums."

Under changes approved by the Blue Shield board, physicians may increase their fees only once a year instead of quarterly as had been the practice.

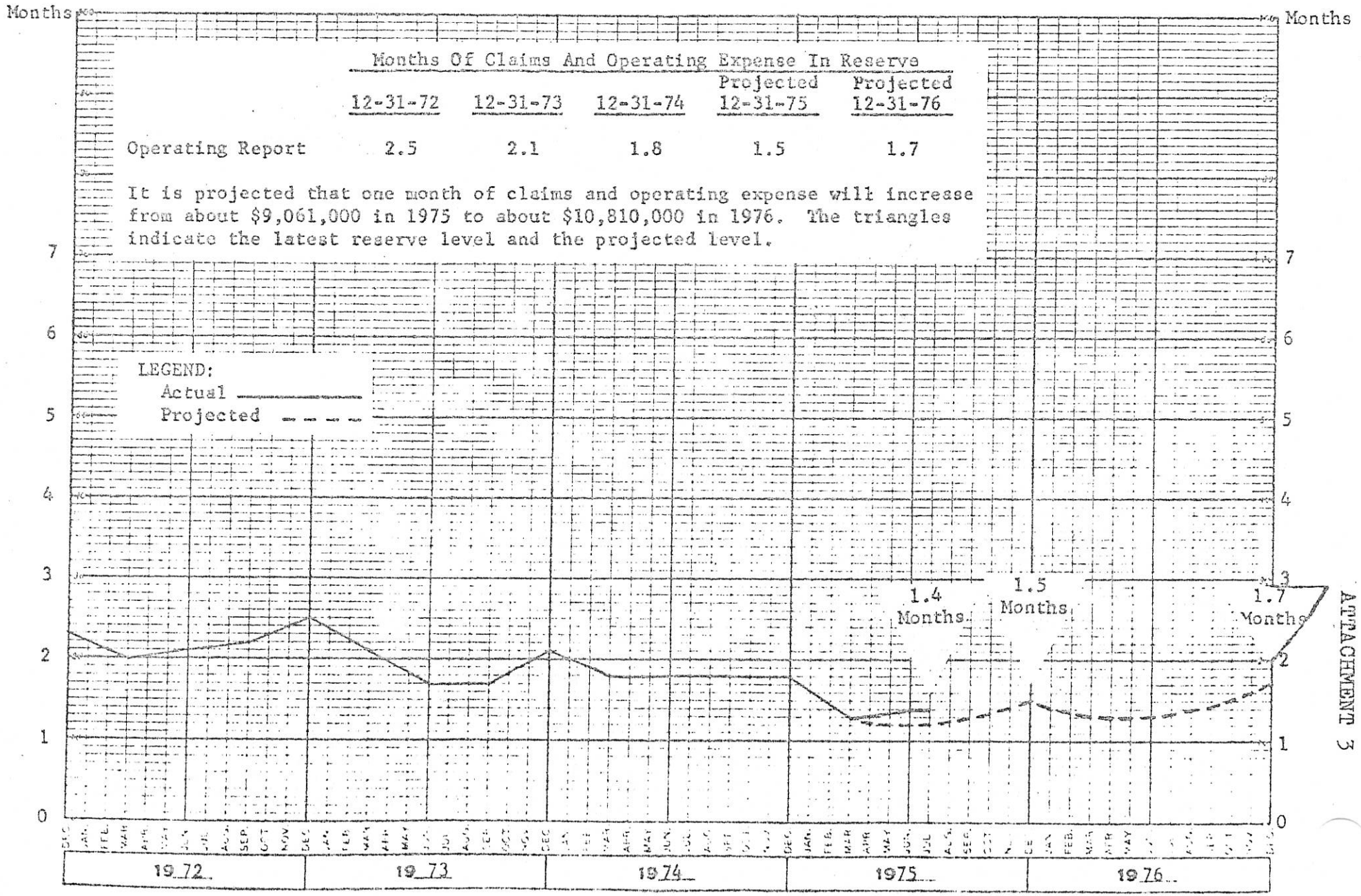
Frank Adae, president of Blue Cross and Blue Shield, pointed out in an interview yesterday that the vast majority of physicians do not raise fees more frequently than once a year and many let their fees go unchanged for years.

Physicians contract with Blue Shield

Continued on Page 6B

ATTACHMENT 2

BLUE CROSS
NUMBER OF MONTHS OF CLAIMS AND OPERATING EXPENSE IN RESERVE



ATTACHMENT 3

ATTACHMENT 4

Fueling Inflation

Health Fees Up

Washington (AP)—Hospital and doctor costs have increased 50 per cent faster than the economy as a whole since May and if unchecked could cost Americans $13 billion additional over the next two years, Caspar W. Weinberger, secretary of health, education and welfare, said yesterday.

"This we must and will moderate," he said.

Engaging in a little economic jawboning of his own, Weinberger told the American Association of Medical Clinics that health care price increases "are a prominent fuel in the acceleration of the nation's inflation."

Since federal wage-price controls expired April 30, physician fees have risen at an annual rate of 19.1 per cent and hospital charges at an annual rate of 17.7 per cent, he said.

"With such skyrocketing inflation, the costs for health care in this fiscal year will increase an additional $4 billion and, next year, an extra $9 billion," the secretary said.

More than 70 per cent of those higher costs will come out of consumers' pockets, he said.

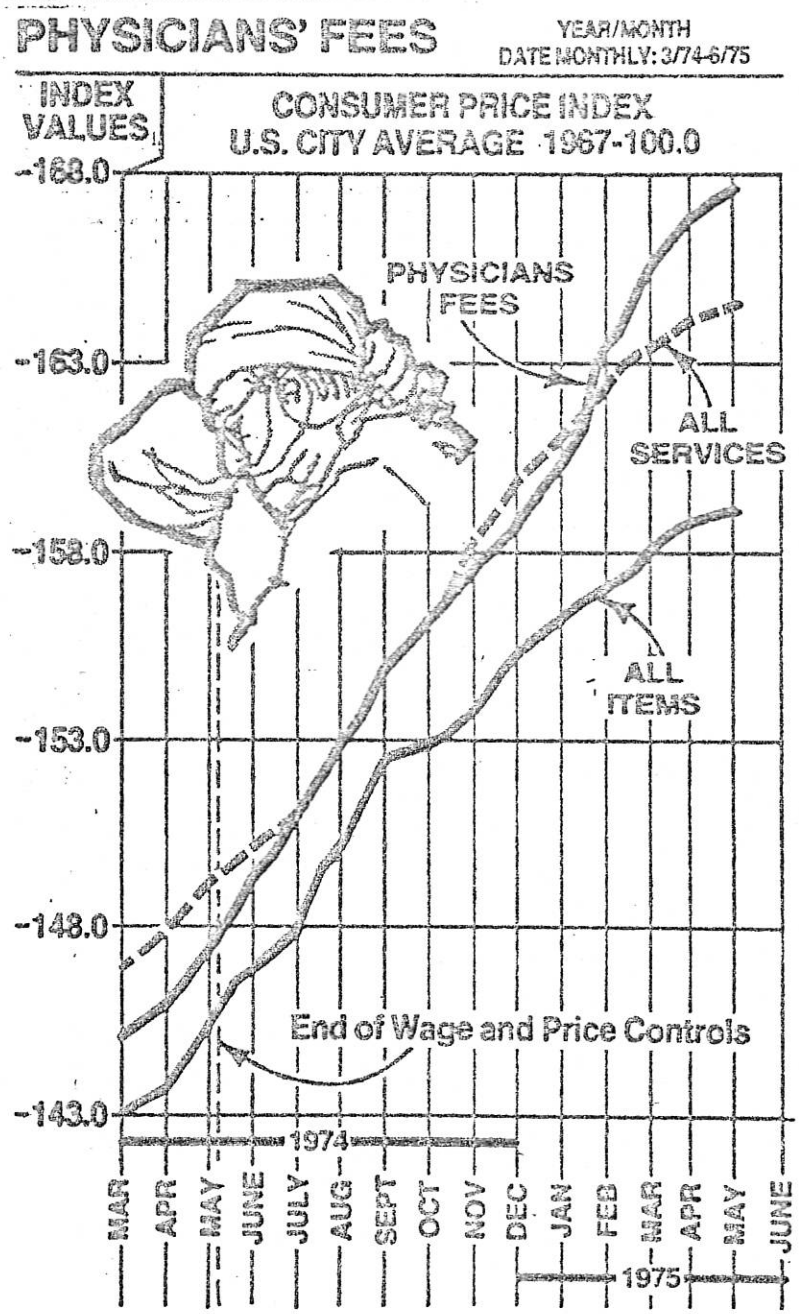
In a statement released later in the day, Weinberger estimated that inflationary health costs may add $1 billion to the federal budget even if the rate of increase begins to taper off.

If not controlled, he said, the increases will hinder biomedical research into cancer and heart disease and seriously jeopardize development of a comprehensive national health insurance system.

Unless private health leaders can halt the trend, Weinberger said, "the American people are in real trouble on the health care front."

Weinberger had opposed dropping federal controls on the health industry. He told Congress last spring that federal spending could rise $500 million to $600 million a year if controls were lifted.

ATTACHMENT 5



Fees Lead

While the costs of goods and services, as measured by the Consumer Price Index, have risen steadily since January, physician's fees surged, as shown on this graph prepared by the federal Bureau of Labor Statistics. The leap in doctors' fees has nearly drained the cash reserve of Kansas City Blue Shield.

Blue Cross Plan to Control Costs?

By William Stockton
A.P. Science Writer

Washington (AP)—The cost of medical care in America is rising more rapidly than the cost of living, partly because Blue Cross and Blue Shield hesitate to impose cost controls on doctors and hospitals.

A 3-month investigation by the Associated Press indicated that Americans might save millions, and perhaps billions of dollars, annually if Blue Cross and Blue Shield changed some of their practices.

Instead, the rates of the two nonprofit, public service health insurance organizations are climbing steeply across the country.

In Florida, Blue Cross asked the state insurance commission for a 26 per cent rate hike. Florida Blue Shield asked 14 per cent more.

In North Carolina, one class of Blue Cross-Blue Shield coverage would increase 43 percent, other classes 28 per cent.

New Jersey Blue Cross sought approval of a 29 per cent hike from state insurance officials, Blue Shield 34 per cent. Increases in Colorado range from 10 per cent to 40 per cent.

Rates vary widely among the 144 Blue Cross and Blue Shield plans. Coverage for one family now often costs between $50 and $65 a month.

The price of a semiprivate hospital room has risen 197 per cent—to $100 a day or more in many hospitals—in the last 10 years, according to government statistics. Doctors' fees have gone up 85 per cent while the cost of living has risen 68 per cent.

The A.P. investigation indicates that Blue Cross and Blue Shield—now involved in the payment of 30 per cent of the nation's $100 billion annual medical bill—might be able to put the brakes on this inflation.

All of the Blue Cross and Blue Shield plans, for example, agree to pay the hospital and doctor costs of elective surgery without requiring a second opinion on the need for that surgery. After New York union instituted a second opinion requirement in its health insurance plan in 1972, elective surgery declined by 17.5 per cent among the 11,000 union members at a saving of $7 a member. A doctor who testified at a congressional hearing projected this saving nationwide and came up with a saving of $5 billion.

Blue Shield, which pays doctor bills, gives doctors a major say in determining the amounts Blue Shield will pay them for treating subscribers. But the formula used encourages doctors to raise their bills, because the bills they submit help determine the reimbursements they get. Only five of the 71 Blue Shield organizations have put limits on this system.

Blue Cross, which provides hospital insurance, is helping finance more than 60,000 surplus beds in American hospitals. Only three of the 73 Blue Cross plans require hospitals to verify the medical necessity of a hospital admission at the time it occurs and police length of stay. Only a third of the plans negotiate in advance the hospital rates they'll reimburse. The rest either pay what a hospital charges or audit a hospital's bills after they're received. Each of these problems can add to medical care costs, the A.P. investigation found.

Eighty-two million people have Blue Cross coverage and 72 million have Blue Shield, but they have little say in running the 144 different and largely independent plans or in determining rate increases. Each plan has a board and many of these boards are dominated by doctors and hospital officials or by laymen chosen by medical societies and hospital officials, the A.P. investigation found.

In the states where Blue Cross and Blue Shield must secure government approval, rate increases in the past often have been granted routinely. A few states however, are questioning Blue Cross and Blue Shield policies among them New Jersey, Pennsylvania, Ohio, Vermont and Michigan.

"The system is out of control. The little guy is going to be priced out of Blue Cross and Blue Shield coverage," said Dan Demlow, Michigan insurance commissioner.

Michigan Blue Cross sought a 39 per cent rate hike earlier this year and Blue Shield a 26 per cent increase. Demlow cut the $316 million increase request in half, citing specific areas where he said the two organizations had not moved to control doctors and hospitals. Blue Cross and Blue Shield are challenging his authority in court.

One of Demlow's objections was to the advertising budget. He said most of it was for image building and of no direct benefit to subscribers.

His objection raises the whole issue of administrative costs, which run between $800 million and $900 million annually for all 144 plans, or between 5 and 10 per cent of total income. A study of insurance industry statistics shows that Blue Cross and Blue Shield spends less of the consumer's dollar on administration than do the commercial insurance companies. But there are problems. The salaries of the five top executives in each plan, for example, not only kept pace with inflation from 1966 to 1974, but rose an additional 30 per cent. The salaries of the presidents ranged last year from $32,500 in Allentown, Pa., to $110,000 in New York City.

Blue Cross and Blue Shield had their beginnings in the economic hard times of the 1930s. They were organized by doctors and hospitals seeking to assure financial solvency by selling prepaid health care.

The idea quickly spread. Doctors and hospitals in many states sought and obtained special legislation making Blue Cross and Blue Shield nonprofit, public service organizations exempt from the taxes and restrictions placed on the commercial insurance industry.

The organizations grew up under the control of doctors and hospitals—a domination that still has its impact.

The American Medical Association helped found the parent national Blue Shield association. Until the early 1970s, the American Hospital Association owned the Blue Cross trademark and had directors on the board of the national Blue Cross Association.

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The two health insurance systems also are the principal intermediaries for the distribution of $15 billion annually in federal health care funds, most of it Medicare for the elderly.

Blue Cross and Blue Shield now want to secure a major role in any national health insurance organization Congress might create. They might attain it simply by virtue of their nationwide computer facilities. No other organization has the computer capacity in place that would be required to run a national health insurance program.

Health insurance industry observers consider Blue Cross and Blue Shield coverage among the best available in terms of benefits to consumers. They have led the industry in offering comprehensive coverage for groups and individuals. They have led in offering nonhospital benefits, paying for walk-in emergency room care in full and offering coverage of home nursing care that otherwise might require a more expensive hospital room.

ATTACHMENT

But the various plans often shy away from compelling doctors and hospitals to make changes. For example, more than 50 Blue Cross plans will pay for tests done outside a hospital and needed in preparation for hospitalization. This testing can shorten some hospitalizations one or two days, but none of the 50 plans requires this preadmission testing. It's optional.

Ties to Bankers

Millions of dollars in federal and private funds entrusted to Blue Cross and Blue Shield are being channeled through banks with officers who sit on the health organizations' boards.

Some of the money is federal Medicare funds administered by Blue Cross and Blue Shield. Medicare officials say at least 11 banks have had excess balances in Medicare checking accounts this year. They say steps are being taken to require competitive bidding for banking services to eliminate this problem by December.

The A.P. investigation has identified at least 25 banks around the country with officers involved in a potential conflict of interest because they also are directors of Blue Cross and Blue Shield plans.

Huge amounts of money are involved in Blue Cross and Blue Shield financing. The two organizations act as intermediaries and distribute $15 billion annually in federal health care funds, mostly for Medicare. They also collect $15 billion annually in private subscriber premiums. In all, Blue Cross and Blue Shield handle 30 per cent of the $100 billion spent annually by Americans for medical care.

National Blue Cross and Blue Shield policy requires only that directors of the 144 state and local plans disclose conflicts of interest to fellow board members.

The A.P. investigation did uncover bankers who are directors of local Blue Cross or Blue Shield plans but who do not have health plan funds in their banks. One bank official in Kansas repudiated the practice.

"Basically that would be a conflict of interest," said John A. O'Leary Jr., of Peoples State Bank in Luray, Kan. He was appointed to the Kansas Blue Shield Board by the state's governor.

"I'm an honest Irishman and we don't run a railroad that way," O'Leary said. "In good conscience we couldn't keep any Blue Shield money. I represent the people of Kansas."

The A.P. found 20 Blue Cross or Blue Shield plans with bank officials as directors and Medicare funds deposited in the banks of these directors. There also were at least 20 cases in which funds collected from private subscribers were deposited at banks with representation on Blue Cross and Blue Shield boards. In each case, other banks also received money from the health organizations.

Philadelphia Blue Cross, for example, has three board members who also are directors of the Philadelphia Savings Fund Society. State insurance records show that of the $9 million that Blue Cross invested in interest-paying savings certificates in 1974, $3.7 million went to the Philadelphia Savings Fund Society.

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Blues 'Fail to Control Costs'

ATTACHMENT

By William Stockton
A.P. Science Writer

Washington (AP)—The cost of medical care in America is rising more rapidly than the cost of living, partly because Blue Cross and Blue Shield hesitate to impose cost controls on doctors and hospitals.

A 3-month investigation by the Associated Press indicated that Americans might save millions, and perhaps billions of dollars, annually if Blue Cross and Blue Shield changed some of their practices.

Instead, the rates of the two nonprofit, public service health insurance organizations are climbing steeply across the country.

In Florida, Blue Cross asked the state insurance commission for a 26 per cent rate hike. Florida Blue Shield asked 14 per cent more.

In North Carolina, one class of Blue Cross-Blue Shield coverage would increase 43 percent, other classes 28 per cent.

New Jersey Blue Cross sought approval of a 29 per cent hike from state insurance officials. Blue Shield 34 per cent. Increases in Colorado range from 10 per cent to 40 per cent.

Rates vary widely among the 144 Blue Cross and Blue Shield plans. Coverage for one family now often costs between $50 and $65 a month.

The price of a semiprivate hospital room has risen 197 per cent—to $100 a day or more in many hospitals—in the last 10 years, according to government statistics. Doctors' fees have gone up 85 per cent while the cost of living has risen 68 per cent.

The A.P. investigation indicates that Blue Cross and Blue Shield—now involved in the payment of 30 per cent of the nation's $100 billion annual medical bill—might be able to put the brakes on this inflation.

All of the Blue Cross and Blue Shield plans, for example, agree to pay the hospital and doctor costs of elective surgery without requiring a second opinion on the need for that surgery. After New York union instituted a second opinion requirement in its health insurance plan in 1972, elective surgery declined by 17.5 per cent among the 11,000 union members at a saving of $7 a member. A doctor who testified at a congressional hearing projected this saving nationwide and came up with a saving of $5 billion.

Blue Shield, which pays doctor bills, gives doctors a major say in determining the amounts Blue Shield will pay them for treating subscribers. But the formula used encourages doctors to raise their bills, because the bills they submit help determine the reimbursements they get. Only five of the 71 Blue Shield organizations have put limits on this system.

Blue Cross, which provides hospital insurance, is helping finance more than 60,000 surplus beds in American hospitals. Only three of the 73 Blue Cross plans require hospitals to verify the medical necessity of a hospital admission at the time it occurs and police length of stay. Only a third of the plans negotiate in advance the hospital rates they'll reimburse. The rest either pay what a hospital charges or audit a hospital's bills after they're received. Each of these problems can add to medical care costs, the A.P. investigation found.

Eighty-two million people have Blue Cross coverage and 72 million have Blue Shield, but they have little say in running the 144 different and largely independent plans or in determining rate increases. Each plan has a board and many of these boards are dominated by doctors and hospital officials or by laymen chosen by medical societies and hospital officials, the A.P. investigation found.

In the states where Blue Cross and Blue Shield must secure government approval, rate increases in the past often have been granted routinely. A few states however, are questioning Blue Cross and Blue Shield policies among them New Jersey, Pennsylvania, Ohio, Vermont and Michigan.

"The system is out of control. The little guy is going to be priced out of Blue Cross and Blue Shield coverage," said Dan Demlow, Michigan insurance commissioner.

Michigan Blue Cross sought a 39 per cent rate hike earlier this year and Blue Shield a 26 per cent increase. Demlow cut the $316 million increase request in half, citing specific areas where he said the two organizations had not moved to control doctors and hospitals. Blue Cross and Blue Shield are challenging his authority in court.

One of Demlow's objections was to the advertising budget. He said most of it was for image building and of no direct benefit to subscribers.

His objection raises the whole issue of administrative costs, which run between $800 million and $900 million annually for all 144 plans, or between 5 and 10 per cent of total income. A study of insurance industry statistics shows that Blue Cross and Blue Shield spends less of the consumer's dollar on administration than do the commercial insurance companies. But there are problems. The salaries of the five top executives in each plan, for example, not only kept pace with inflation from 1966 to 1974, but rose an additional 30 per cent. The salaries of the presidents ranged last year from $32,500 in Allentown, Pa., to $110,000 in New York City.

Blue Cross and Blue Shield had their beginnings in the economic hard times of the 1930s. They were organized by doctors and hospitals seeking to assure financial solvency by selling prepaid health care.

The idea quickly spread. Doctors and hospitals in many states sought and obtained special legislation making Blue Cross and Blue Shield nonprofit, public service organizations exempt from the taxes and restrictions placed on the commercial insurance industry.

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The A.P. investigation has identified at least 25 banks around the country with officers involved in a potential conflict of interest because they also are directors of Blue Cross and Blue Shield plans.

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Philadelphia Blue Cross, for example, has three board members who also are directors of the Philadelphia Savings Fund Society. State insurance records show that of the $9 million that Blue Cross invested in interest-paying savings certificates in 1974, $3.7 million went to the Philadelphia Savings Fund Society

In Alabama, M. F. Moor Jr., president of the First National Bank of Birmingham, is a member of the Alabama Blue Cross-Blue Shield board. The organization had two Medicare accounts at First National in 1974. In addition, Alabama Blue Cross-Blue Shield invested $43 million last year in interest-paying bank certificates of deposit. About half the money was invested at First National at one point during the year; the other half at a dozen other banks, according to state insurance records.

State insurance officials in several states say they're aware of the relationships between banks and Blue Cross-Blue Shield. No action has been taken, they say, because no laws have been violated.

"I would always want good financial people on my board; they're essential," says Ted Sherlock, president of Maryland Blue Cross, which has one banker on the 27-member board.

In response to a request under the Freedom of Information Act, officials of the Social Security Administration, which supervises Medicare, analyzed the questionable Medicare accounts found by A.P. Social Security identified 11 accounts with excess balances during the first quarter of 1975. This meant the banks had federal money to invest beyond that needed to pay each bank for its checking account service.

The excess balances ranged from $8,597 at the Marshall & Ilsley Bank in Milwaukee to $163,717 at Mid-Atlantic National Bank in Newark, N.J. Six other banks had accounts with deficits—an indication these banks provided services at less than cost during the period.

Medicare records and Polk's Bank Directory, a standard reference, list three salaried presidents of Blue Cross organizations who also serve as directors of banks where Medicare accounts are kept. They are Tom L. Beauchamp, Jr., president of Texas Blue Cross-Blue Shield and a director of the Republic National Bank of Dallas and its parent company, Republic of Texas Corp.; Alden E. Flory, president of Blue Cross of Virginia and a director of Second National Bank in Richmond, and Leo E. Suycott, president of Wisconsin Blue Cross and a director of Marshall & Ilsley in Milwaukee. In a fourth case, Robert P. Taylor was president of Blue Cross-Blue Shield of Arkansas and a director of Worthen Bank and Trust in Little Rock until his resignation recently from his Blue Cross-Blue Shield post.

Social Security listed excess balances in Medicare accounts at Republic National as well as Marshall & Isley during the first quarter of the year. Second National in Richmond and Worthen Bank and Trust had deficit balances, indicating the banks were carrying the cost of the checking accounts.

No one knows how much the relationships between Blue Cross-Blue Shield and banks might cost the federal government or more than 80 million Blue Cross and Blue Shield subscribers, but there are hints.

Who Runs Blue Cross?

The millions of Americans whose monthly payments finance Blue Cross and Blue Shield have no say in choosing the directors who run the non-profit, public service organizations.

The result is that consumers have little control over how Blue Cross and Blue Shield represent their health care interests in dealing with doctors and hospitals.

The issue is a major one for two reasons:

- Rate increases have averaged about 30 per cent in the last year for many of the 144 Blue Cross and Blue Shield plans while the cost of living in this period increased 12.2 per cent.
- Blue Cross and Blue Shield seek a role in any national health insurance program Congress might create.

The A.P. investigation has found that:

- Many boards of directors of local Blue Cross and Blue Shield plans are dominated by doctors and by hospital officials, or by laymen chosen by medical societies and hospital officials.
- The boards of directors of most Blue Cross and Blue Shield plans are self-perpetuating. The directors themselves nominate and elect new members, or re-elect themselves. The subscribers have no voice in these elections.

Connecticut Blue Shield in a typical example. The plan's bylaws state that board members elect new members. The chairman of the board appoints several directors to a nominating committee that selects candidates for board vacancies. The 20-member board is composed of eight practicing physicians, a retired physician, the president of Connecticut Blue Shield, four corporation executives and a retired executive, a lawyer, a vice-president of Southern New England Telephone, a union official, a bank president, and a woman connected with the Connecticut Housing Authority.

- In response to increasing pressure in recent years many state and local plans have added public members to their boards to represent subscribers. But the A.P. investigation found that many of these public members were chosen under the self-perpetuation concept by incumbent board members and not by subscribers. In some cases—Tennessee, Florida, Idaho, Los Angeles, for example—state medical societies or hospital associations make the selections.

Blue Cross says there are 1,885 board members for all its state and local plans. Of these, 1,138, or 69 per cent, are listed as consumer representatives. However, 161 of the consumer representatives, or 14 per cent, also are hospital trustees. Most of the rest are corporate executives, bankers and lawyers. Blue Shield's latest statistics, compiled last summer, say board composition averages 40 per cent public membership.

The 27-member board of directors of Maryland Blue Cross, for example, is required to have a majority of public members. Three of the directors are doctors, two are hospital administrators, three are hospital trustees, eight business executives, one is a banker and one is the salaried president of Maryland Blue Cross. The rest are Baltimore's director of finance, a state senator, three union leaders, a college professor, a public school teacher, the chancellor of the University of Maryland at Baltimore and an employee of the State Roads Commission.

In Arkansas, 12 of the 21 Blue Cross-Blue Shield board members in 1974 were doctors or hospital officials. The organization added three public members a few years ago. One was the daughter of Sen. John L. McClellan (D-Ark). She is a housewife. The two others were hospital trustees.

Late last year, the Arkansas insurance commissioner, Arch Monroe, ordered the two hospital trustees to resign or relinquish their posts as trustees because of the potential conflict of interest. They resigned before Monroe's order but after the issue had been raised. Subsequently, the board elected new directors to fill these two vacancies and others. As a result of that election, the Arkansas Blue Cross-Blue Shield board now has its first black and its first representative of organized labor.

Second Opinion?

None of the 144 state and local Blue Cross and Blue Shield plans require a subscriber to obtain a second opinion from a medical specialist before undergoing elective surgery.

A number of Blue Cross and Blue Shield officials stated in interviews that requiring second opinions would reduce unnecessary surgery and New York City Blue Cross-Blue Shield is studying the possibility of a second opinion program.

Fear of reaction from doctors is seen as the main reason the idea has been slow to develop.

A union with its own health insurance program, the 11,000-member United Storeworkers in New York, requires second opinions for elective surgery with the union paying

Continued on Following Page

Questioned

☆'Needless' Health Payments

Continued from Preceding Page

for the second opinion. Since 1972 consulting surgeons have recommended against 17.5 per cent of the surgery that union members' doctors proposed. The money saved equals $7 a member a year.

There are other problems in the Blue Shield system, which pays the doctor bills and some other medical costs of about 72 million people while Blue Cross pays hospital bills.

Nearly 40 million Blue Shield subscribers are covered under a system that pays their doctor bills according to a schedule of fixed fees. If the fees are less than the doctor's actual bill, as they often are, the doctor is free to collect the difference from the patient.

Most of the remaining subscribers, about 32 million people, have their doctor bills paid in full by Blue Shield. The doctors agree not to bill additional amounts to the patients. But under a complicated formula, the doctors themselves determine what Blue Shield will pay them for their services. Under this formula, a doctor who holds down his fee one year is penalized the following year when Blue Shield recalculates its maximum payments to doctors.

The formula for calculating doctor fees, known as the Usual, Customary and Reasonable Fee Program, or U.C.R. for short, was described as inherently inflationary in an opinion issued in July by a New Jersey Insurance Department hearing examiner. The opinion dealt with a Blue Shield rate increase request.

The federal government's Medicare program uses a similar system to pay doctors, but Medicare officials placed a ceiling July 1 on yearly increases. Only five of the 71 Blue Shield Plans have such a ceiling, Blue Shield says.

Blue Shield officials say their system is the best way to assure payment of a fee that doctors consider reasonable so they will not insist on billing subscribers additional amounts.

An Associated Press survey also found that:

• Fewer than 15 Blue Cross or Blue Shield plans force a doctor or hospital to stand the cost of care found to be medically unnecessary. At the balance of the 144 plans the doctors and hospitals can turn to the patient to collect the bill if Blue Cross or Blue Shield won't pay it.

• Most Blue Shield plans refuse to reveal to subscribers the range of doctors' fees in a particular area for a particular service. Armed with such information, a Blue Shield subscriber facing gall bladder surgery, for example, might easily judge where his own doctor's fee fell in relation to others.

The UCR payment program is built around a history of a doctor's charges and what other doctors with the same specialty and in the same geographical area are charging.

For example, a doctor might have sent bills for appendectomies in 1974 ranging from $300 to $340, although he knew full well that his actual reimbursement from Blue Shield would be less than his bills and would be based on what had been billed in 1973. Nevertheless, with his bills he established an average or usual charge of $320 for appendectomies in 1974. The new higher average appendectomy charge in calendar 1974 helps get this doctor's Blue Shield reimbursement increased for the fiscal year beginning July 1, 1975.

The formula works this way: The doctor's average appendectomy charge is compared with the average charges for each of the other doctors in his area, fees for an appendectomy which usually vary. While this doctor's average was $320 for the operations he performed, another's average might be $290, another $350, another $400 and another $425.

The wide range of average charges would be used to figure the area's customary charge for appendectomies. The customary charge would depend not only on each doctor's average price, but also on the total number of appendectomies at that price. If all the doctors in a particular area performed 100 appendectomies in 1974, and 90 of them were performed at $290, $350, then $350 would become the maximum Blue Shield payment for appendectomies in the year starting July 1, 1975.

Under the Blue Shield formula only those bills in the upper 10 percentiles are discounted. Those doctors who had achieved averages of $400 or $425 in 1974 would receive payments of only $350. But that's more than the reimbursements to the doctors who held the line on fee increases in 1974 and achieved lower average charges. The doctor with a $320 average charge is reimbursed only $320 in Blue Shield's next fiscal year.

Medicare uses a similar payment system, but instead of paying 90 per cent of the appendectomies in full as Blue Shield did, it pays only 75 per cent.

Blue Shield national officials said five of the 71 Blue Shield plans limit over-all UCR increases in fees, but they declined to identify the plans, saying that in some cases doctors are unaware of the limits and might protest their existence.

Hospital Costs

Americans who have Blue Cross health insurance apparently are paying millions of dollars extra each year because most of the Blue Cross organizations are not imposing strict cost controls on hospitals.

The A.P. investigation found three major problem areas: Surplus beds, the failure of most Blue Cross plans to negotiate hospital budgets and charges in advance and failure to prevent unnecessary hospitalization or to limit the length of hospital stays.

The Blue Cross Association, with headquarters in Chicago, has urged the 73 independent Blue Cross plans around the country to impose cost controls on the hospitals whose bills they pay.

Some plans have. A nationwide projection of their savings, and the findings of health care economics researchers, indicate that if all Blue Cross organizations determinedly pushed these cost controls, they might reduce their subscribers' annual payments for hospital services by $500 million or more. That would be about $7 for each of the 80 million people covered by Blue Cross health insurance. Their monthly dues paid $8.3 billion in hospital bills last year.

Blue Cross is the most powerful financial force in the affairs of American hospitals. In addition to the billions paid each year to cover the bills of hospitalized subscribers, Blue Cross is the intermediary for the federal government's Medicare program for the elderly. In this role, the 73 plans channeled $10.7 billion in federal funds to hospitals last year.

The A.P. investigation found that:

• Nearly every Blue Cross plan helps hospitals support surplus beds. Interstudy, a respected health care research organization, and various experts say the country has 60,000 to 100,000 surplus hospital beds and their average maintenance cost is conservatively estimated at about $55 daily. Blue Cross pays about 20 percent of this cost. Thus, assuming there are 80,000 such extra beds, they are costing Blue Cross subscribers $320 million annually.

• Only three Blue Cross plans—in New Jersey, Rhode Island and Kansas—require hospitals to certify the medical necessity of a subscriber's hospitalization and then monitor the stay to make certain the patient remains only the time necessary. Where monitoring has taken place, some hospitals have achieved an average reduction in stays of a quarter of a day or more. The average hospital stay for 8.8 million Blue Cross subscribers last year was 6.74 days. A reduction of a quarter of a day would have saved $110 million last year.

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OL. 96. NO. 8 MAIN EDITION ★ KANSAS CITY, THURSDAY, SEPTEMBER 25, 1975—42 PAGES

Sports, 471-3
Want Ad

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United Way Asks More From Area Physicians

The United Way campaign is pressing Kansas City's physicians to be more generous in contributing to the United Way.

According to a letter mailed out earlier this month by Jerome Scott, Jr., chairman of the campaign this year, two-thirds of the city's physicians did not contribute last year.

Scott's letter to the United Way's board of directors urged them to write their family physicians and ask them to give their "fair share" of 1 per cent of their annual income.

"As you may know," Scott, who is also president of the United Missouri Bank of Kansas City, wrote, "we have not solved the problem regarding fair share giving by the physicians. For example, last year only 33.6 per cent contributed, for a per capita gift of $35.46.

"Of the approximate 960 members of the Jackson County Medical Society, only 167 gave $100 or more. The physicians' per capita gift of $35.46 compares to an over-all average of $20.19 for employee groups, and in our 25 largest firms the employee per capita, mostly blue collar workers, was $40.26.

"Not only is the physicians' per capita below that of blue collar workers, but when one considers that a fair share gift is 1 per cent of income, it is apparent we have not scratched the surface . . ."

Scott continued that he and Richard D. Gray, executive vice-president of the United Way, appeared before the medical society recently to request their backing and co-operation.

"It was a nice meeting," he wrote, "but I feel the giving levels will not really be changed unless we have some special assistance and help."

As a post script to his letter, Scott added: "If you have time, you might write your dentist, too!"

Dr. Warren Wilhelm, president this year of the Jackson County Medical Society, when asked to comment on the letter, revealed that he had received a similar letter that had been sent to physicians themselves over the city.

"As an individual," he said, "I support the United Way, but I'll not have anyone telling me what's a reasonable gift. We physicians are giving so damned much time to community betterment in other ways, it's a matter of our own personal conviction whether we want to give additional money to this community effort."

Dr. Wilhelm added that the board of the medical society recently took an official position in support of the United Way and agreed to encourage its membership's support.

ATTACHMENT 7

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Committe on the Financing of Medical Education

UNDERGRADUATE MEDICAL EDUCATION
ELEMENTS — OBJECTIVES — COSTS

REPORT OF THE COMMITTEE ON THE FINANCING OF MEDICAL EDUCATION

CHARLES C. SPRAGUE, M.D., CHAIRMAN

[From the Kansas City Times, Oct. 11, 1973]
COST OF MEDICAL EDUCATION FIGURED

WASHINGTON (AP)—The first survey of its kind suggests that it cost from $16,000 to $26,000 a year for the medical education of an American doctor.

That adds up to between $64,000 and $104,000 for a 4-year course.

A special committee of the Association of American Medical Colleges, the professional organization that represents the nation's 114 private and public medical schools, made the report.

Students themselves pay about $2,200 a year in tuition. The rest of the cost is paid by federal, state, local and private funds.

FOREWORD

Contemporary medical education takes place in institutions engaged in a broad range of interrelated activities designed to serve and further national purposes and objectives in health. The growing need for information to illuminate the complex programmatic and fiscal circumstances governing medical schools has long been a concern of the Association of American Medical Colleges and of the medical education community. To help meet this need, the Association in 1970 formed the Committee on the Financing of Medical Education to conduct and sponsor studies designed to provide the data base for recommendations on matters of policy relating to medical education and its financing.

Shortly after it was formed, the Committee recognized that before it could turn to a consideration of how medical education should be *financed* it would have to develop guideline estimates of the *costs* of the resources required for contemporary medical education. Attention was focused initially on the cost of the education program leading to the doctor of medicine degree.

The Committee has tried to place the estimation of the cost of undergraduate medical education within the perspective of the total education and training of the physician and the other programs and activities of the complex modern medical school. To accomplish this goal, this report describes the institutional setting in which education takes place and defines the elements and objectives of the undergraduate medical education program. The resources required for this educational process measured in dollar terms are estimated from studies carried out in medical schools. The quantitative cost measurements are then presented, followed by a discussion of the Committee's views on the issues surrounding cost measurement.

The findings of this first study of the cost of undergraduate medical education may be relevant for an assessment of the current Federal policy to provide financial support for undergraduate medical education, based on the number of medical students enrolled. There have been suggestions that future levels of such support be determined by estimates of the costs of the educational program leading to the M.D. degree.

It is the intention of the Committee to present in a subsequent report its views of the mechanism through which the costs of undergraduate medical education should be financed. An equitable distribution of these costs among the immediate beneficiaries of the process and society, and the maintenance of the institutions in which the educational process necessarily takes place must be assured if the benefits which have flowed from the medical school are to continue to play their important role in advancing the health of the nation.

The Committee wishes to express its deep appreciation and gratitude for the assistance of the members of its Task Force groups, the representatives of the medical centers that were studied, and the Association's staff in developing the data on which this report is based.

Charles C. Sprague, M.D.
Chairman
AAMC Committee on the

ATTACHMENT 8

[The attachments referred to follow:]

Attachment 1.

WAGE EARNER, MARRIED, 4 DEPENDENTS, FILING A JOINT RETURN

	$5 per hour, 2,080 hr per year, $10,400 per year	$10 per hour, 2,080 hr per year, $20,800 per year	$48 per hour, 2,080 hr per year, $99,840 per year
Less standard 12 percent	−$1,248	−$2,496	−$11,980.
4 dependents: 750 times 4 equals $3,000	−$3,000	−$3,000	−$3,000.
Taxable income	$6,152	$15,304	$84,860.
Federal tax	−$1,028	−$3,086	−$36,159.
Net (1 form of net spendable income)	$5,124	$12,218	$48,701.
Net dollars per hour per year	$2.46	$5.87	$23.41.
How many net hours of work equal $15	6.09	2.55 hr	0.64 hr or 38 min.
Tax income	$6,152	$15,304	$84,860.
$5,000 medical bill	−$5,000	−$5,000	−$5,000.
3 percent of tax income	+$184	+$459	+$2,546.
New tax income	$1,336	$10,763	$82,406.
New tax income	$1,336	$10,763	$82,406.
New Federal tax	−$190	$1,968	−$34,735.
New net spendable income	$1,146	$8,795	$47,671.
Net dollars per hour per year	$0.55	$4.22	$22.92.
How many new net hours of work equal $15	27.27 hr equal 3½ days.	3.55 hr equal ½ day.	0.65 hr, or 39 min.
Original Federal tax, no medical deduction	$1,028	$3,086	$36,159.
New Federal tax with $5,000 medical deduction	−$190	−$1,968	−$34,735.
Government pays	$838	$1,098	$1,424.
Individual pays	$4,162	$3,902	$3,576.
Total medical expenses	$5,000	$5,000	$5,000.

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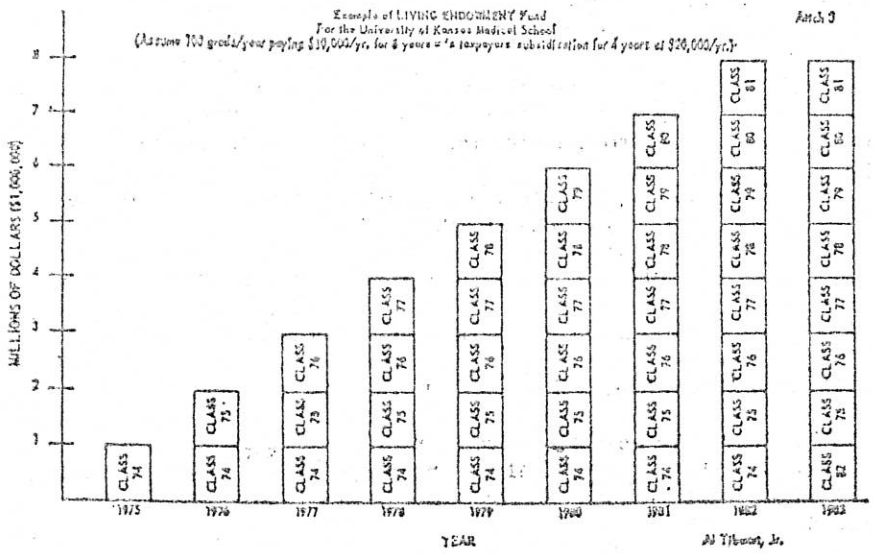
WASHINGTON (AP)—The first survey of its kind suggests that it cost from $16,000 to $26,000 a year for the medical education of an American doctor.

That adds up to between $64,000 and $104,000 for a 4-year course.

A special committee of the Association of American Medical Colleges, the professional organization that represents the nation's 114 private and public medical schools, made the report.

Students themselves pay about $2,200 a year in tuition. The rest of the cost is paid by federal, state, local and private funds.



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HEARINGS

BEFORE THE SUBCOMMITTEE ON
PUBLIC HEALTH AND ENVIRONMENT
OF THE COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS — First and Second Sessions
on National Health Insurance and Health Care
December 10, 11, 12, 13 and 14, 1973; February 1 and 2, 1974

STATEMENT OF AL W. TIKWART, JR.

Mr. TIKWART. Yes, sir; and a taxpayer.

Mr. ROY. And a taxpayer, right.

We would welcome your statement, Mr. Tikwart.

Mr. TIKWART. First, I would like to thank you gentlemen for this opportunity. I probably won't be as polished because I don't have the facilities at my command, as do the large organizations that have appeared on the panel. I would like to present some facts that affect the middle American.

Health care costs are too high for the average American. If you would kindly look at attachment 1, gentlemen, I have taken three incomes per hour, $5 per hour, $10 per hour, and $48 per hour. The $5 income is $10,400 per year; the $10 is $20,800, and the $48 is $99,000 plus.

The taxable income on the first man would be $6,000; on the $20,000 man, $15,000; on the $99,000 man, $84,000. I am assuming a 12 percent standard deduction, also that this is an average family of 4 dependents, filing a joint return. The Federal tax for this person of $5 per hour amounts to $1,028. His net after that, gentlemen, is $5,124; the net per hour is $2.46. I have used taxable income less Federal tax to represent one possible type of net spendable income. One could use other statistics such as the U.S. Department of Labor cost of living to arrive at a net spendable income.

The person making $20,000 per year, his net per hour is $5.87.

The person making $48 per hour, his net is $23.41 per hour.

How many hours would it take of work to pay a $15 bill? You know, the average cost in this city ranges from $10 to $25 for an office visit that takes 5–15 minutes of the doctor's time. $15 for the man making $2.46 per hour would be 6 hours of work; for the man making $20,000, it is almost 3 hours of work; for the man in the $100,000 bracket, it is 38 minutes.

What if an individual would have a $5,000 medical bill that is covered by insurance? I have gone through the tax ramifications, and it shows that for the man earning the $5 per hour, his earnings now would be $1.55 per hour for a year's work. The man earning $20,000,

his earnings are $4.22 per hour; and the man at $100,000 is $22.92.

With this $5,000 bill that could occur—and this amount is not uncommon. We've had two boys in the last 4½ years, each of whom has required surgery and $5,000 is a realistic figure for surgical and hospital care. For the individual earning $5 an hour, the government pays about $838 out of the taxes; the individual pays almost $4,162.

The $20,000 a year man, the Government pays the big sum of $1,098 and the individual pays $3,920.

While the man in the $100,000 bracket, $1,424 is paid by Government taxes, well, it is almost $2,700, and he pays only $3,576. This is less than the man earning one-ninth of what the $48 man earns.

We have a tax inequity here. Once again it shows that our income tax system is very progressive for the middle class but regressive for the rich $100,000-year man.

Why have medical costs increased? I feel that there are two reasons for this.

First off is the great demand for services in a field which was already a seller's market, while the supply of doctors has increased very little. This increased demand was brought about primarily by Government social programs such as medicare and medicade.

No. 2, I also believe that the present system of private insurance, such as Blue Cross and Blue Shield, also have added greatly to the cost. This is due to the fact that doctors, the people who control the supply, serve as members of these boards. We have heard today from the Blue Cross representative the exact figure, a 50–50 ratio—50 percent doctors–50 percent public. I wonder what the census is on the public's portion of these boards? How many people are the young persons, you know, 20, 21, how many are the young married, the young family men on these boards? How many are the retired-type people? These are the persons who bear medical expenses and I question that they are proportionally represented on these boards which are so influential in setting medical fees.

But I know as soon as a certain percentage of the doctors in a community charge a fee for a given service, then Blue Cross-Blue Shield automatically raises the payment for that service. This shows little regard, I believe, for the true supply-and-demand situation.

How can we keep this spiraling cost of medical care down? I believe that it could be done primarily by training more general practitioners, adding to the supply.

Where would we get the money to do this? I believe that one practical solution to this question would be to see that the State and the Federal Government are repaid for the $16,000 to $26,000 average per student per year for medical education. This figure was obtained from a study done by the Association of American Medical Colleges, the professional organization that represents the Nation's 114 private and public medical schools. The article appeared recently in the Kansas City Times, Thursday, October 11, 1973, see attachment 2 [p. 562].

I believe that a doctor, whose education prepares him to be in the top percentiles of income earners in the United States, should pay back the portion of his education cost borne by the taxpayer. No other field, engineering, social sciences, tradesmen, plumbers, any of us, is so heavily subsidized, and in no field is the remuneration so great so quickly.

I have worked in the medical-dental consulting field, and I have studied between 75 and 100 practices, both rural and urban in Kansas and Missouri. It is common for a new doctor in his first year to have a net income after expenses of $30,000 to $40,000; also after a short time, a period of 3 to 5 years, practices of $80,000 to $150,000 net per man are common, and I could go on.

If each new doctor would be required to pay directly, in dollars or services, the approximately $80,000 taxpayer-paid portion of his educational costs, a sizable pool could be created.

For example, in the State of Kansas, medical tuition is about $800 per year. I have had a hard time trying to obtain these figures from local officials at K.U. Medical Center. But this is the figure that I was told was correct. Other medical schools in the area, public and private, range from $3,800 to $5,000. Assuming the difference between the student tuition of $800 in Kansas and the cost of medical education stated earlier, taxpayers are bearing a $20,000 subsidy per medical student per each year a student is in medical school. We, in Kansas, subsidize the education of people to enter the top percentages of income.

Yet, if each year the 100 graduates of the K.U. Medical School would pay $10,000 a year for the first 8 years of their practice, a fund would grow to become a living endowment of many millions.

If you look at my attachment 3, it shows that within 8 years, gentlemen, you could have a fund of $8 million that would perpetuate itself a living endowment. If these figures are correct, the $20,000 per year cost to educate a doctor we could triple the enrollment at K.U. and get three times more doctors into the supply and take care of this demand, but to look at demand without meeting the supply of doctors, we are kidding ourselves.

Now, if a doctor would elect a career other than private practice, such as public health service, or public research, public teaching, credit toward this debt to the State could be given.

I would question some things that came up in testimony by the providers. First, I know that doctors, like any student, are in debt when they graduate. The figure of $25,000 to $50,000 was thrown out. You know, gentlemen, there is a tax loophole called income tax averaging which, if used by a doctor, within the first 6 or 7 years, that his tuition costs, and then some, can be paid back again out of tax savings from income averaging. So I don't think it is an idea of just doctors living less years. I think we poor middle-class Americans who are working harder and trying to meet our obligations in a good honest way are the ones who are going to live less, and we don't have $100,000 incomes to afford medical care.

I am sorry for a little bit of emotionalism here. I wanted to keep my talk more on an intellectual plain.

I thank you very much for this opportunity to present my views. In conclusion, I would like my three attachments to be made an official part of this testimony. Also, I would like to say that the local TV, radio, and press—Kansas City Star and Times, gave very little or no advance coverage of this important public meeting on national health insurance. I called local stations and press and they said they had the release but could give no reason why they did not give this meeting coverage. I would also like to go on record and thank station WIBW in Topeka for alerting me of this meeting. This is one radio station that can be counted on to give in-depth news coverage. Thank you, again.

ATTACHMENT 10

THE AFFLUENT M.D.

Physicians are rapidly becoming one of the most affluent groups in American society. A mass of statistics confirming that fact has been compiled by the Congressional Research Service (CRS) of the Library of Congress under the title, "Facts About Physicians' Fees and Incomes."

It is not available to the public but can be obtained from a member of Congress.

The amount of money earned by physicians is a key item in the debate over various national health insurance programs, which is why CRS prepared the report.

It shows that between 1967 and 1972, the median net income of office-based physicians rose from $32,000 to $42,700.

In that same period the annual earnings for chemists rose from $13,068 to $18,581; for engineers from $13,272 to $18,268, and for attorneys from $13,644 to $23,448.

The report points out that the increase in physicians' incomes was not accompanied by any significant change in patient visits per week; in fact, general practitioners and pediatricians earned more money taking care of fewer patients.

Tax Breaks Among Bennett's Proposals

By Ray Morgan
Kansas Correspondent

Topeka—An income tax reduction and an end to the 3 per cent sales tax on prescription drugs are part of a $13-million tax reform package proposed today by Gov. Robert Bennett of Kansas.

The income tax reduction, outlined before a joint session of the Kansas Legislature, would come primarily by increasing the personal exemption from $600 to $750.

Bennett made it clear, however, that revenue lost because of the tax cuts must be made up, either by reducing spending or by changing some provisions of the tax law. Revenue-producing changes he suggested would make some provisions conform to federal income tax requirements and eliminate the use of certain federal tax tables in computing state income taxes.

"The passage of a tax reform package as I have described would grant the reforms that are necessary without reducing present or future resources of the state," Bennett said. "While admittedly it is politically palatable to support tax reduction, unless we can honestly say we have done that which needs to be done, unless the dollars are available in excess of our needs or unless we can offset one revenue loss with another revenue gains, such a program is fiscally irresponsible.

"While tax reduction can be funded at the national level with borrowed money or with newly printed currency, no such option exists to the government of this state where we must serve our people within and not beyond the dollars which they currently provide."

The income tax reduction would cost about $10 million, Bennett said, and eliminating the sales tax on prescription drugs would cost $3 million.

In his message, which took about 30 minutes to deliver, Bennett also recommended:

- That a new medium-security prison be built to house 200 inmates.
- That the death penalty be reimposed for murders committed during a kidnaping, highjacking of an aircraft or sex crime, as well as killing for hire.
- That a statewide water policy committee be created to make sure water resources are adequately safeguarded.
- That the funding of public schools stay the present level and formula, pending outcome of court challenges to the school finance act.
- That a constitutional amendment be implemented on land-use value assessment for farmland. Under land-use value, farmland is assessed according to what it produces, not its market price.
- That steps be taken to ensure adequate medical care for rural and other underserved areas. The governor has suggested excusing medical students from tuition costs for each year they work in underserved areas of the state.
- That steps be taken to help local governments with financial problems. However, Bennett expressed opposition to the idea of allowing cities and counties to impose local income taxes of up to 10 per cent because that could be a source of assistance for school districts under the school finance act.

Bennett made it clear that his budget, to be presented before a second joint session next Monday, will require no new state tax increases. He said he was primarily interested in dealing with future long-range problems of the state.

"The problems enumerated and the solutions suggested are by no means exclusive but rather indications of my concern which have come through two years of service as governor, through listening to recommendations in my travels throughout the state and through the study of the hundreds of research documents and proposals which have crossed my desk in recent months," Bennett said. "I realize that there are Kansans who would do more, just as there are Kansans who would do less and it is between these two extremes that a program for progress and a plan for posterity must be realistically and responsibly developed."

This is how the governor described his idea for getting doctors into ruarl areas through tuition payments:

"First, the student would be charged tuition roughly equal to the full cost of his professional education. Second, the student would have the option of paying these costs in full or asking the state to underwrite these costs in return for a written commitment that the student would practice in an underserved area of the state for a specific period of time. Under the plan, for each year the student practices in the underserved area, one year of the tuition costs would be written off the student's obligation to the state."

Bennett expressed opposition to a proposal that students admitted to the University of Kansas Medical Center be selected on a geographic basis. "It is falsely optimistic to assume a geographical weighting system would assure the return of rural students to their home communities," he said.

Bennett said a death penalty la
should have safeguards—mainly
provision that the Kansas Supren
Court review each death penalty i
posed and rescind any sentence t
justices thought unjustified.

Although Bennett urged the legisl
tors to start implementing use-val
assessment for farmland he said
was not mandatory that they come
with something this year: "Good fai
with this popular action of the peop
requires near perfect implementati
as much or more than it does sw
action for action's sake alone."

He specifically singled out problen
in defining agricultural land, t
method for determining the incon
potential of the land, the effect on ot
er property taxpayers and a meth
for recouping taxes when actual ag
cultural land is used by land specul
tors to take advantage of " law.

Farmland assessmer sely r
lated to the school fina ue, Be
nett said.

Highlights of the Governor's Recommendations

By the Associated Press

Taxes: Bennett supports increasing the personal exemption on state income taxes from $600 to $750 a person and eliminating the state's 3 per cent sales tax on prescription drugs. However, he advocates this only if the potential $13.3 million loss of revenue is offset by means he has outlined.

State Aid to Cities: The governor questions increasing state aid to local units of government at this time and opposes the idea of taxing at the state level while spending at the local level. He supports improvement of the local option sales tax, but cautioned against giving local units power to enact local income taxes until pending school finance cases are settled in court.

Use Value Assessment: Bennett urges deliberate study of the impact on farmland assessment of switching from fair market value to production capcity for property tax purposes. He urges caution in defining agricultural land and setting a method for determining income potential, and advocates averaging over a period of years and tax recoupment when farmland is sold for another use.

Health Care: The governor proposes 12 more residencies in the primary care fields to lure more doctors into them, continued support of the family practice residency program, increased recruitment of medical students from western Kansas and creation of a system that would finance the education of a medical student for each year he spends practicing in an underserved area.

Water: He recommends creation of a state "water resources policy committee" made up of representatives of state agencies now involved in water planning or research.

Energy: He proposes a preliminary engineering study on a coal-fired power plant at Kansas State University, a study on developing a solid waste-fired steam generation plant at the University of Kansas, spending $2.5 million on energy conservation projects, and setting irrigation as a preferred use of intrastate natural gas.

Death Penalty: Bennett uges reimposition of the death penalty for certain crimes. He advocates two trials—one to determine guilt and a second to determine punishment.

J

REPORT OF THE TASK FORCE ON THE RAINBOW-UNIT

THE TASK FORCE

The Rainbow Unit Task Force was appointed in June, 1976, by the boards of directors of the mental health centers of Johnson and Wyandotte Counties. The purpose of the Task Force was to "Review the current program of the Rainbow Unit, assess how that program meets the needs of the community and prepare a report and recommendations" for the health center boards.

The Task Force was composed of six members from each of the two counties. During the course of the year several members were unable to continue participation. For the past few months the work of the Task Force and the writing of this report has been done by the seven remaining members: Ray Bailey, Paul Bowman, Mary McGowan, Carol Potter, Kate Pruessner, Annette Thurston and Linda Urda. The writers of the report acknowledge the contributions made by Task Force members: Toni Becker, Tom Copeland, Joe Fagan, Helen Haubold and Milt Roberts.

The Task Force also wishes to express special thanks to Rick Gallaher of the Johnson County Mental Health Center for making provisions for our meetings, sending out notices, organizing and distributing the questionnaire and providing information and input in our early deliberations. Throughout the study, the Task Force found the staff of the mental health centers and the Rainbow Unit most cooperative.

The Task Force began its examination of the Rainbow Unit by searching for useful information and by collecting and analyzing that information. As this was done, certain areas emerged as ones of recurring concern and importance. This report is addressed to these problem areas and recommendations are made relating thereto.

Methods

A number of documents were identified as important sources of information about the Rainbow Unit. The study of these reports and records helped define the problem areas discussed in the report:

1. The minutes of the Joint Coordinating Committee.
2. The original grant application for funding of the Rainbow Unit.
3. Explanation and justification of the Rainbow Unit's annual budget.
4. Site inspection reports.

5. Various procedural outlines of the Rainbow Unit.

6. A report on admissions procedures done by Johnson County Mental Health Center Staff.

7. Several studies done by graduate students on admissions and length of stay.

In addition to reviewing the above written reports the members of the Task Force also:

1. Visited the Rainbow Unit and talked with personnel there.

2. Prepared questions and interviewed Mr. Jack Southwick.

3. Some Task Force members attended the coordinating committee meetings as regularly as possible.

4. Met with representatives of community agencies in both counties to assess their knowledge of the Rainbow Unit and how it meets community needs. These included Social and Rehabilitation Services and school systems.

5. Interviewed the Rainbow Unit Auxiliary.

6. Interviewed Jane Sieverling and Anne Jinnings on the history of the Rainbow Unit and expectations of the original Task Force that set it up.

7. Received input from the directors of the mental health centers and some of their staff.

8. Prepared and distributed a questionnaire to staff members of the Rainbow Unit, the mental health centers and Kansas University Medical Center - Emergency Room (KUMC-ER).

A major effort of the Task Force was to develop the questionnaire that was distributed in each unit by an administrator of that unit. (A sample copy is attached to this report.) The response was almost 100%. The number of questionnaires distributed in the units varied. Of the fifty-two respondents, twenty-five were from Rainbow Unit, fifteen were from Wyandot Mental Health Center, ten were from Johnson County Mental Health Center and two from KUMC-ER. As the results were tabulated, specific issues emerged and were noted for further study and recommendation.

At times we were overwhelmed by the complexity of our task and realized that we could not begin to analyze all the matters that presented themselves. Therefore, we are addressing this report to the specific areas that we felt had the greatest impact on the quality of patient care. We defined our role as one of study and fact finding and therefore this is not a scientific report, but rather a statement of our impressions and observations gained from the preceding sources.

RELATIONSHIPS BETWEEN RAINBOW UNIT AND MENTAL HEALTH CENTERS

Relationships between the mental health centers and Rainbow Unit do not appear to be as warm and cooperative as policy and procedures manuals indicate. Although there is communication and apparent cooperation between the agency directors through the monthly meetings of the Joint Coordinating Committee, there is no structure for communication at the staff level. This is indicated by reports from Rainbow Unit staff who say they do not get adequate client information from the mental health centers at admission, while staff at the mental health centers report they get little or no feedback during hospitalization and inadequate discharge information. There appears to be more cooperation between Rainbow Unit and Wyandot Mental Health Center than between Rainbow and the Johnson County Center. This, no doubt, is due to the proximity of the Wyandot Center to Rainbow, and to the greater use of Rainbow by Wyandotte County residents. (1)

Although comments from mental health center staff sometimes give the impression that the mental health centers lack confidence in the abilities and performance of Rainbow Unit, this may be related to the high degree of frustration over the difficulties in getting clients admitted and in getting information after admission. Some feel that cooperative efforts are one-sided with Rainbow making little effort to "get along" with the centers. There appears to be a power struggle between Rainbow, with its identification with the state, and the mental health centers. This is indicated in the failure of the centers to refer patients for partial hospitalization. There is also indication that frequently the centers feel they can do a better job of therapy (and also collect the fees) than is done by Rainbow in their partial hospitalization program. (2)

The centers say they do not want to operate the Rainbow Unit but do want to establish policy to carry out their community-oriented philosophy of treatment so there will be continuity for the patient. This philosophy is mandated by community needs, by county authorities, and by federal guidelines for county mental health centers. Philosophy and procedures for the Rainbow Unit are determined by the state, and are frequently in conflict with those of the centers. There is no structural provision for resolving such conflicts. There is a Joint Coordinating Committee but it has no authority. Consequently, these conflicts surface in this committee, but, according to our observations, are seldom resolved.

Conclusion

A comment made by a respondent to the questionnaire expresses our impressions in this manner:

> "We seem to have difficulty keeping in mind we all have one goal - to help rehabilitate these individuals to being useful and productive citizens. We seem more concerned as to who has more power and how much responsibility we can shift from one to another. Instead of all being units in a group, we want to be separate and in complete control."

ADMISSIONS

Patients are admitted to Rainbow Unit through one of three structures: Wyandot Mental Health Center, Johnson County Mental Health Center, or KUMC-ER. Rainbow Unit, itself, has no "walk-in" admission procedures.

From the mental health centers and referring agencies, we found that, in general, the process of admission to Rainbow Unit is difficult, inefficient and frustrating. Consequently, it is often not considered as a resource. Rainbow staff in charge of admissions are, reportedly, often very hard to reach and unavailable for consultation. Telephone inquiries to Rainbow about available space and the possibility of admission are frequently unsatisfactory. Centers complain that sometimes incorrect information about availability of space is given by Rainbow staff and that too often Rainbow does not have room for the needed admissions.

Contact with Rainbow Unit for admitting information is especially hard to make after working hours and on weekends. Patients, even crisis patients, are sometimes sent home for the night or the weekend because admission cannot be arranged at these "off" hours. (3)

Rainbow staff feels that many inappropriate referrals are made by the mental health centers and KUMC-ER. Rainbow is not equipped to handle severely acting-out patients or patients who do not wish to stay for treatment, and yet some such referrals are made. Other inappropriate referrals sent to Rainbow include geriatric patients, patients requiring medical attention, out-of-county patients, patients awaiting transfer to another institution, and patients who are unable to benefit from the kind of treatment given at Rainbow. Rainbow staff feels that KUMC-ER interns and residents are not given the proper information about the function and facilities of Rainbow Unit so they can make appropriate referrals. (4) (5)

The Task Force is concerned about those patients who are sent home for the night or the weekend to await admission to Rainbow Unit. No effort seems to be made to assure the patient's return at the proper time for admission, nor is any attention given to the care they receive in the intermediate time. The Task Force is equally concerned that the "walk-in" patient who comes to Rainbow requesting admission must first be sent to one of the three admitting agencies. No help is given to get the patient to the proper admitting center, but rather, the patient has the sole responsibility to get there himself. (6)

Conclusions

Patients are certain to "fall through the cracks" with the present admission procedures. We believe that professional, responsible treatment should be given at the time it is needed — whenever and wherever it is requested. Therefore, we recommend: (7)

1. That the purpose, function and facilities at Rainbow Unit be clearly defined and that a program be set up

to inform staff members of admitting agencies so that referrals will be screened more carefully.

2. That written admission procedures be made available to appropriate staff at referring agencies and at Rainbow Unit. (8)

3. That if inpatient space is not available, then an interim treatment plan should be formulated cooperatively between Rainbow Unit and the referring agency.

4. That the mental health centers, through their crisis units, refer clients directly to Rainbow Unit during night hours and on weekends, rather than to KUMC-ER. K.U. would continue to refer clients to the three units as does any community agency. (9)

COMMUNICATION

Another area of major concern that emerged was the problem of communication between the centers and Rainbow Unit. It is our impression that there is no free-flow of patient information once the patient has been admitted to the Rainbow Unit. Comments from the centers indicated that they are not given regular reports of the progress on patients that they have referred to the Rainbow Unit. Patient transfers and consultation with other agencies are often accomplished by Rainbow without notifying the referring center. (10)

Rainbow Unit reports that information given them at the time of patient admission is often inadequate. They felt that this was particularly true of admissions that came from the courts, Johnson County Mental Health Center and KUMC-ER. Often the information arrives late, is clothed in jargon, is not complete, is inaccurate or illegible, includes no reason for the referral and omits testing information and assessments. (11)

At discharge, the patient often is not referred back to the mental health center and information that is given is late, inadequate and contains no recommendations for follow-up therapy and procedures. When planning for referral of patients to alternate care facilities, referring agencies need a longer period of notification that patients are being discharged from Rainbow Unit. (12)

Frequent complaints emerged about the telephone service at Rainbow. It is difficult to make phone contact on weekends and evenings. Additional complaints are that the receptionist often does not know to whom to direct the calls; conflicting information is given on availability of bed space and Rainbow Unit staff are frequently in meetings and unavailable for consultation.

Conclusions

We did not sense a cooperative and ongoing communication between the centers and Rainbow, nor a total integrated treatment plan that guides the patient from the community to hospitalization and back to the community.

We find that discharge planning is a serious gap in the continuity of patient care. Planning for discharge should be a cooperative venture which is worked out to the satisfaction of both the hospital and the patient as well as the referring agency.

We feel the role of telephone receptionist is a very important position. To family, in-coming patients, and professionals it is their first impression of the Unit.

We recommend:

1. That written weekly or bi-monthly notes of patient progress be sent to the referring center and, when appropriate, the agency that originated the referral.

2. That discharge possibilities be discussed on an ongoing basis with the referring agency, and such agency should be included in the discharge planning, helping to facilitate referral to community resources as part of the discharge procedures. Rainbow staff should make an immediate appointment for the patient at the appropriate community mental health center for follow-up. No patient should be dismissed without a follow-up appointment.

3. That the position of receptionist be filled with trained personnel, on duty at all times. This is not a task that should be left to chance.

PARTIAL HOSPITALIZATION

Throughout the course of study of the Rainbow Task Force, the Rainbow Unit partial program and the Day Activity Program of the Johnson County Mental Health Center were regularly mentioned. Both programs are seen as valuable and necessary to the community. Both are providing services and serving residents. Numerous concerns were repeatedly mentioned, however, and we feel it important to share our observations. It is our impression that confusion exists in the community regarding the nature of both programs, means of referral and coordination between programs. (13)

The Wyandot Mental Health Center does not have a partial program; it relies on Rainbow for placement of all persons requiring partial hospitalization.

While both the Johnson County Mental Health Center and the Rainbow Unit have partial programs, the programs appear to be structured differently, used differently, and attended by persons who are functioning at different levels. The Johnson County partial program emphasizes group discussion of problems and feelings and is open for individuals to join at any time. In contrast, the Rainbow Unit partial program stresses activities as opposed to discussion, is often closed to "new" membership, and involves more severely disturbed clients than at the Johnson County Center.

The Rainbow Unit Task Force believes that the partial program at Rainbow Unit is not being utilized to full benefit, particularly by the Johnson County Mental Health Center which has a Day Activity Program of its own. Recent statistics indicate that few Johnson County adults are admitted directly to the Rainbow Unit partial program from Johnson County Mental Health Center. (Many Johnson County residents do utilize the Rainbow Unit partial program, however, as they are transferred from inpatient to partial as a transition to the community.) (14)

While the Rainbow Unit was originally designed as a deterrent or alternative to inpatient hospitalization, it does not appear as though it is being used this way; instead, it has become, essentially, a "half-way out" program as transition from Rainbow Unit inpatient to the community.

After study, the Rainbow Unit Task Force has determined that transportation is a significant factor in the limited usage of the partial program. Both centers are hesitant to refer clients who have long distances to travel. In addition, a major road block to successful transportation to the Rainbow partial program is the reluctance of Social and Rehabilitation Services to interpret Rainbow Unit appointments as eligible for transportation reimbursement. We urge Social and Rehabilitation Services administrators to broaden interpretation of the regulations to include attendance at the partial program as a justifiable expense.

Lack of child care facilities has also prevented persons from using Rainbow Unit's partial program. (15)

According to the Johnson County Mental Health Center staff, on occasion, they have had trouble getting children admitted into Rainbow Unit's partial program due to lack of space. Apparently, some persons hesitate to use Rainbow's program if the child cannot be admitted to the school program. There is little use of the after-school program by either center. Again, transportation is part of the problem.

Conclusions

The Task Force believes the partial program at the Rainbow Unit could be better utilized by both counties through a program of education and cooperation. Therefore, we recommend: (16)

1. That representatives from the Johnson County Mental Health Center and Rainbow Unit get together to

educate one another about the specifics of each program, type of client served, means of coordination between the two, means of referring, and means of preventing duplication. The goal should be to educate all staff, and encourage cooperation and utilization of both programs when appropriate.

2. That transportation to partial programs be improved. This has been mentioned numerous times as a significant problem and should be regarded as such by administrators of all facilities.

3. That the possibility of creating a child care program for children of partial patients or of contracting with an accessible day care center for such services be investigated.

4. That the staff of Rainbow Unit and the mental health centers be encouraged to use Rainbow Unit's partial program as an alternative to hospitalization and that Rainbow Unit staff consider the partial program as a possible alternative for every referral from the community.

5. That follow-up for patients in partial programs be provided in order that patients receive assistance in the transition to the community or to another facility.

OTHER CONCERNS

In addition to the major areas identified we noted these additional findings:

1. We are aware that Rainbow Unit is not equipped to handle violent patients, however, patients are admitted whose acting-out behavior requires a special room to hold them temporarily. In no instance should such patients be detained in regular rooms that are not designed for that purpose. Special, safe facilities should be provided.

   It repeatedly surfaced that there is a definite community need for a facility to house the violent and aggressive patient. While this may not be the function of the Rainbow Unit, we feel the community mental health centers should work cooperatively with the Rainbow Unit and KUMC to examine this community need.

2. Although we did not look specifically at internal problems in the administration of the Rainbow Unit, concerns about personnel, their evaluation and supervision and problems with administrative structure did surface. These were viewed as having a negative influence on the quality of patient care and therefore we suggest that management consultant services be made available to the Rainbow Unit administrator and his staff.

3. There were indications from responses to the questionnaire that there is need for a specific room at Rainbow for patients during the admission process. Out of respect for the patient and his/her right to confidentiality, no interviews should be held in the lobby. (17)

4. It was brought to our attention that children at Rainbow have considerably longer lengths of stay than adult patients. While we acknowledge that treatment of children presents special problems, we express concern over their average length of stay. Rainbow Unit was not designed as a long term care facility and thus every effort should be made to shorten children's periods of hospitalization, both inpatient and partial. The extremely long average length of stay for both programs deters center staff from making referrals.

ADMINISTRATIVE STRUCTURE

The Task Force repeatedly found the administrative structure of the Rainbow Unit to be a major causative factor in problems of its relationships with centers, the community, and in some instances, of its own functioning.

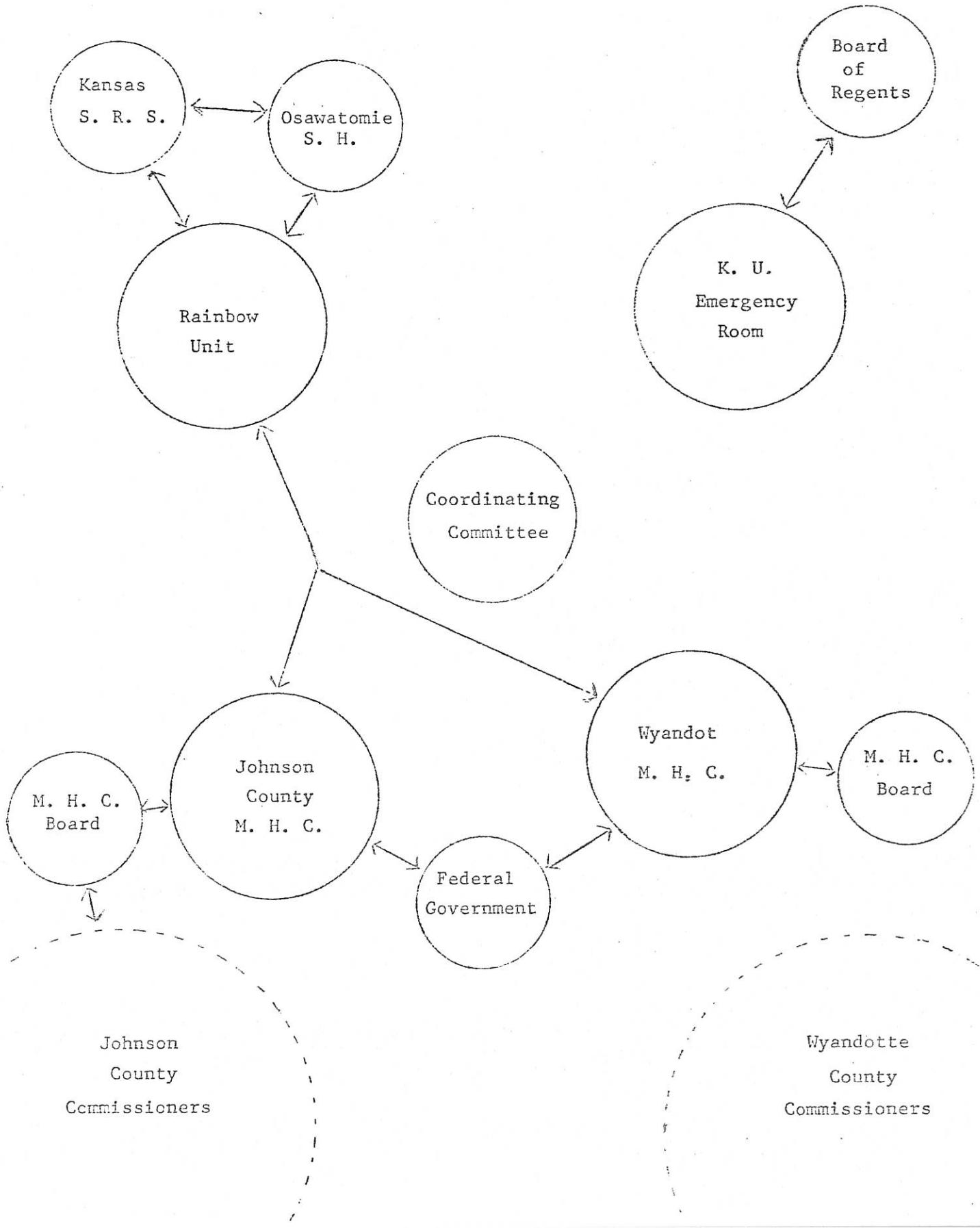
As can be seen from the accompanying charts, the effectiveness of the treatment system of these centers depends heavily upon the coordination and integration of four independent units. Each unit has its own source of authority, i.e., the mental health centers are accountable to their own boards of directors; Rainbow Unit to the Kansas State Department of Social and Rehabilitation Services; and KUMC-ER (through hospital administrative channels) to the Kansas Board of Regents. As each unit is accountable to a separate and different authority, at the same time, no one unit is complete within itself and must depend on other parts of the system for certain services.

The ultimate test of the effectiveness of such a system is the adequacy of the treatment received by individual patients who enter the system through each unit. This Task Force, however, did not have the authority, money or time to study case histories and evaluate treatment; nor would we be equal to such a task. We have depended instead on the judgments of the professionals who function in the system concerning the adequacy of the interrelationships.

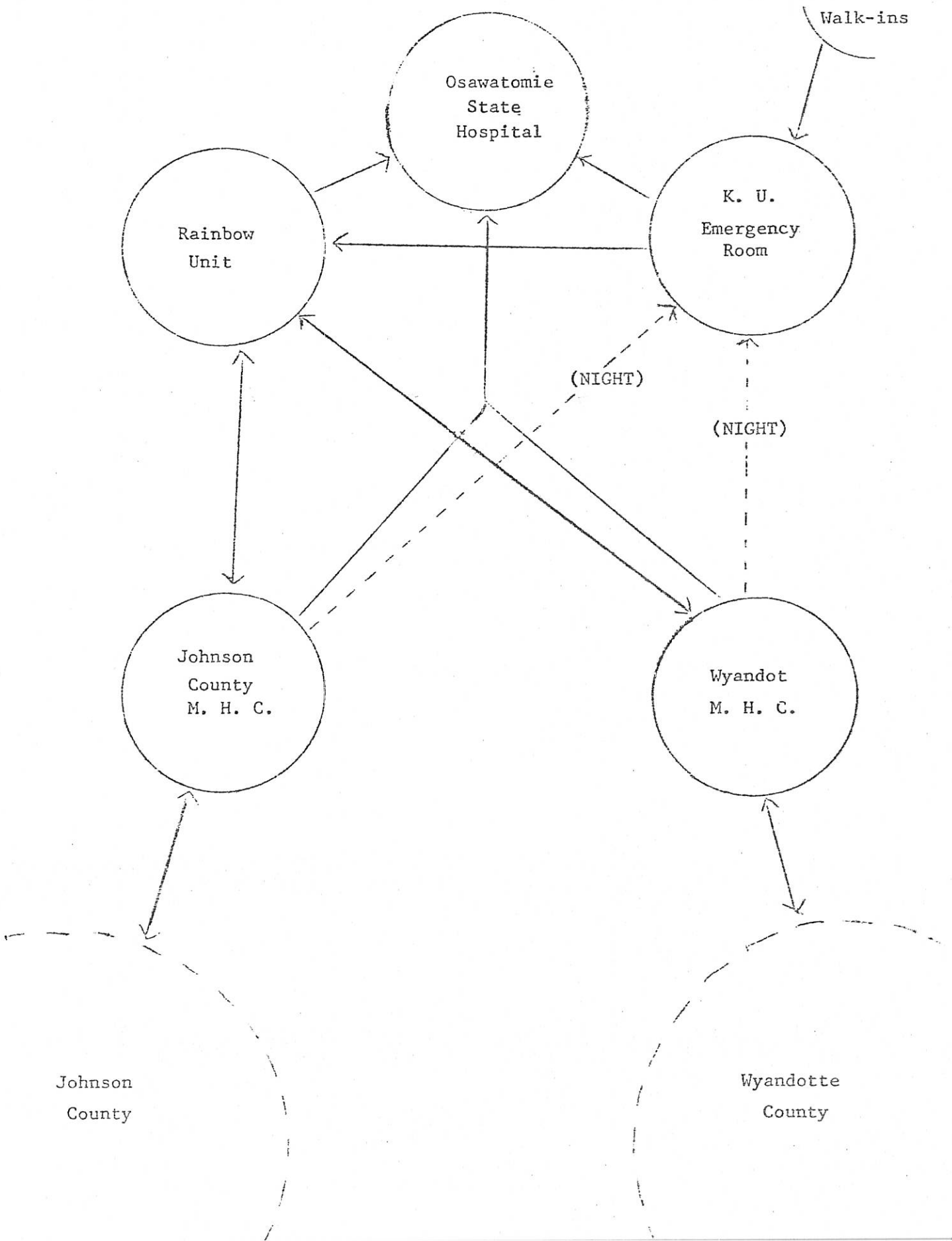
From the content of responses to the questionnaire it was fairly clear that relatively few people were well informed about other units or the relationship between them. This was indicated by the substantial number of "Don't know" answers.

Among those best informed, the attitudes toward other units were heavily negative. Staff members tended to regard their own operations positively, but held expectations of other units that were not met, and tended to conclude that other units were either incompetent or hostile.

AUTHORITY & ACCOUNTABILITY



PATIENT FLOW



Conclusions

The conclusion seems to be that the system is not working as it should. There is some operational evidence that corroborates this conclusion. For example, the partial hospitalization program is not being used for many patients because the two counties, particularly Johnson, do not refer patients to it. The lack of transportation is part of the problem, but not all of it.

This should not be a surprising conclusion. It is only logical to expect that a system built on four completely independent units but requiring a sharing of clients could not work. When the system was formed, professional consultants as well as a local citizens committee both advised that the system would not work without a centralized authority and accountability.

We conclude that the system is not working adequately, not because of the incompetence of people or because of their ill will, but because of inadequate administrative structure. We judge the negative attitudes and problems of treatment to be a result of structure problems, rather than a cause. Therefore, we make the following recommendations:

1. That a central administrative structure be created for the Johnson County Mental Health Center, Wyandot Mental Health Center, and Rainbow Unit with its own board and director, and operating through contracts with the two counties, the state, and the federal government. Such a unit might be structured as a non-profit corporation.

2. If a central administrative structure is not possible, we would recommend that each of the three units operate as separate entities, each complete within itself, except as it contracts for services from other agencies.

3. In either event, the Rainbow Unit should be made an independent unit within the state system, responsible directly to Topeka and not to Osawatomie. (The present arrangement is not logical, and only complicates a complicated system.)

The Kansas University Medical Center - Emergency Room is not included in the above recommendations, because in the section on admissions, we have recommended that evening and week-end referrals be made directly to Rainbow from the mental health center crisis units.

FINALLY

As long as Rainbow Unit is dependent on the mental health centers for referrals, then the number and type of patient is also controlled by the centers. These conflicting powers of control prevent the consumer from receiving the highest quality of health care. Our greatest concern is that when the patient does enter the mental health care system, a lack of communication and cooperation between the units is a serious gap in the total treatment plan.

The Task Force feels that the Rainbow Unit was created out of a definite community need and that it is a valuable resource to the community. We respect and support the concept of community mental health care and see the Rainbow Unit as a vital link in that system.

Task Force Questionnaire on Rainbow Unit Procedures

Instructions. This questionnaire has been prepared by a citizen's Task Force who are reviewing the current program of the Rainbow Unit and assessing how that program meet the needs of the community. Please answer the questionnaire based on your experience with the KUMC-ER, MH Centers, Rainbow Unit relationship during the last six months. Please consider inpatient, outpatient and partial hospitalization services and specify which one you are commenting about. This questionnaire is only for the Task Force and only group data will be reported to the agencies. The number in the corner is only to help check on returned questionnaires since 100% participation of the respondents is needed for adequate data. The number will be cut off before tallying is done. Please use the stamped envelope to return the questionnaire to Mr. Joe Fagan, the Task Force member responsible for collecting the data.

Background Information

Facility where you work_____

Your position or title_____

Unit in which you work (e.g. alcoholism, children's)_____

Work shift: _____ day _____ night _____ evening

1. Is the client subjected to duplicate evaluations as he goes through the referral system necessary for admission to the Rainbow Unit? Yes_____ No _____ If yes, ple describe.

2. Do you get adequate client information:

   (a) at admission to Rainbow Unit? Yes_____ No _____ If no, please describe:

   (b) during hospitalization at Rainbow Unit? Yes _____ No _____ If no, please describ

   (c) at discharge from Rainbow Unit? Yes _____ No_____ If no, please describe:

3. Are telephone inquiries about admissions to Rainbow Unit handled adequately? Yes _____ No _____ If no, please describe:

4. Are you satisfied with:

(a) mental health center referral procedures to Rainbow Unit? Yes_____ No _____. If no, please describe, specifying which center you are describing.

(b) mental health center referral procedures to KUMC - ER? Yes _____ No _____. If no, please describe, specifying which center you are describing.

(c) KUMC-ER referral procedures to Rainbow Unit? Yes_____ No _____. If no, please describe;

5. Does the procedure for handling walk-ins to the Rainbow Unit function well? Yes _____ No _____. If no, please describe:

6. Does the physical set-up of the Rainbow Unit adversely affect admissions? Yes _____ No _____ If yes, please describe.

7. Are there difficulties with client release from Rainbow Unit and referral back to a mental health center? Yes _____ No _____ If yes, please describe, specifying which center you are describing.

8. Does lack of transportation affect the use of the Rainbow Unit? Yes_____ No _____
If yes, please describe:

9. Do you have other concerns, comments or suggestions about the working relationship among Rainbow Unit, mental health centers, and KUMC-ER. Yes _____ No _____. If yes, please describe, specifying whether you are describing adult, children, inpatient or partial hospitalization services.

June 1977

Additional Information

The following brief comments by Program Directors refer to parts of the Task Force report on the Rainbow Unit to give additional information or perspective. Numbers have been placed in the margin of the report to refer the reader to a corresponding note.

1. The Task Force saw little indication from reports by staff that structure exists for communication among staff of the different agencies. Since written policies and procedures exist and forms are available for such, the feeling on the part of staff and the absence of such appropriate communication is more likely related to the phenomena that many staff people are involved in the different agencies and such communications usually require a different pairing of staff for different cases, each contact requiring separate initiative. The mechanism is there, but the motivation is frequently missing as the report points out. As the report indicates elsewhere, staff tend to displace the responsibility for breakdowns.

2. The Mental Health Centers aggressively seek to provide the appropriate "least restrictive form" of mental health treatment to all individuals who come to their attention. In one sense partial hospitalization might be viewed on a continuum between outpatient and inpatient care; it is difficult, therefore, to assess extent of need for partial care and to determine if resources for such care are underutilized.

3. The authority and responsibility for signing in admissions to the hospital must lie, by statute and medical practice, in the hands of a physician. Contact with referring mental health center staff can facilitate the psychiatrist's decision during "off" hours; it is the physician, however, who determines the "medical necessity" of admitting a potential client.

4. The Task Force found that certain Rainbow Unit staff felt that many referrals were inappropriate. While it might be convenient to select patients the Rainbow Unit would like to treat, assurances were given when Federal funds were accepted that the facility would treat a full range of problems. Rather than decide what patients should be excluded from the Rainbow Unit, perhaps more effort should be focused on making the program better able to handle the broad range of patients that should be kept in the community for short term inpatient care.

5. The matter of inappropriate referrals was also said to be related to K.U. Medical Center emergency room residents not being given the proper information about the function of the facilities of the Rainbow Unit. Residents in the emergency room are given annual orientations by Mental Health Center and Rainbow staff. Additionally, a representative of that service attends the Joint Coordinating Committee which meets monthly or more often as needed. Written information is available in the emergency room continuously.

6. Recently, arrangements have been made so that, if the patient is overtly psychotic and demonstrating dangerous and bizzare behavior, the staff at the Community Mental Health Center may be consulted by phone to reach agreement on admission. Occasionally, a staff member from the Mental Health Center might be dispatched to Rainbow to participate in this admission decision.

7. A recent study by a staff member from Johnson County Mental Health Center demonstrated that the total time from the call by a staff person at the Center, through all the evaluation and admission process at Rainbow and until the patient arrives at the cottage at Rainbow, was less than two hours for 67% and less than three hours for 89% of the clients. The range was from one-half hour to four and one-fourth hours, with an average of one hour and fifty minutes.

8. In May, 1977, procedures were assembled, approved, and distributed to update prior admission procedures. The procedures state what action is to be taken if inpatient space is not available.

9. For several years arrangements have existed whereby the Johnson County staff may admit a patient at night directly without going through the emergency room at K.U.M.C. This method of admission is the exception rather than the rule, but it is used approximately once a month.

10. In April, 1977, a new procedure was initiated in which selected regular reports on the progress of patients, taken from the Rainbow medical records, are photocopied and sent to the Centers.

11. By agreement, admissions to the Rainbow Unit come only through the Mental Health Centers or through K.U.M.C. emergency room. The Mental Health Centers' procedures require that the following information is forwarded to the Rainbow Unit upon transfer of a client:

(1) Transfer Form - stating need for transfer and current status.
(2) Intake or Evaluation Report - describing client situation, symptomatic picture, dynamic formulation, treatment plan, prognosis, and diagnosis (may be supplemented by most recent progress report if not transferred immediately after intake).
(3) Client Information Form - demographic information.
(4) Medical History/Reports - if available (the Centers do not have facilities, staff, or mandate to perform such assessments).

12. A recent study by a staff member from Johnson County Mental Health Center demonstrated that 79% of patients discharged from Rainbow were referred to the Center or other community care agency upon discharge. About half of those who were not referred left the hospital AWOL and were not available to work out a referral.

13. The report frequently refers to a partial hospitalization or day activity program of the Johnson County Mental Health Center in Mission. As explained in supplemental material provided by the Task Force, the Johnson County program mentioned is simply a supportive group therapy experience that provides daily contact for individuals who need only a group therapy experience. This is something that the Rainbow Unit does not provide either programmatically or in a location convenient to some of the participants. The Task Force did not attempt to determine whether there were individuals in Johnson County needing a partial hospitalization experience, such as provided by the Rainbow Unit, who were not getting it. While the attendance in partial hospitalization at the Rainbow Unit is running much higher at the present than when the study was done, it is important to point out that the least restrictive form of care is practiced by the Johnson County Mental Health Center. It would be inappropriate to put people in a partial hospitalization program because there were vacancies as opposed to outpatient group therapy when that is what is desirable.

14. The number of patients served at any one time in the partial program has increased from approximately 40 to 80 between July, 1976, and June, 1977, for an increase of about 100%.

15. The facility was built with a child care room and a walled in small outdoor play area for caring for children of parents utilizing daytime services. Staff has never been appropriated for that program and as a result the Rainbow Unit is using the facility for other purposes.

16. Since staff have exchanged visits and communicate about patients regularly, it is speculated that other factors alluded to in the areas of administrative control, organizational identity, control of the patient, etc. encourage displacement of a problem, i.e. underutilization, to another agency.

17. Admission interviews are now being conducted in private offices.

Rainbow Partial Program - Day Activity Program Mission Mental Health Cent

Relationship between Rainbow Partial Program and Day Activity Program

Throughout the course of study of the Rainbow Task Force, the Rainbow Unit partial program and the Day Activity Program of the Johnson County Mental Health Center were regularly mentioned. Firstly, both programs are seen as valuable and necessary to the community. Both are providing services and serving residents. Numerous concerns were repeatedly mentioned, however, and we feel it important to share our observations. It is our impression that confusion exists in the community regarding the nature of both programs: in the community services offered, served, scope, use of, availability of programs, means of referral and coordination between programs.

The Wyandotte Mental Health Center does not have a partial program, but relies on Rainbow for placement of persons requiring partial hospitalization.

The Johnson County Mental Health Center at Mission has a Day Activity Program which typically consists of morning (9-12 a.m.) group therapy. It is loosely structured and groups are open for individuals to join at any time. The group therapy provides an opportunity for persons to become aware of, and discuss their feelings. The original design of the Day Activity Program at Mission intended it as an activity program with one hour of discussion and the remainder of time for crafts, activities and field trips. According to Mission staff, the program changed as a result of a change in the type of client served. There are now fewer severely disturbed clients and more who are capable of discussing problems. Therefore, the field trips and crafts were essentially eliminated from the Mission program.

According to Rainbow staff the partial program at Rainbow Unit is basically a "half-way out" progam as transition from Rainbow inpatient to the community. It reportedly was designed as a deterrant or alternative to inpatient hospitalization but it is not currently being used in that way. The Rainbow Unit partial program is less discussion or "group therapy" oriented than the Mission program. Rainbow emphasizes activities such as occupational therapy, music therapy, art therapy, and field trips. Rainbow staff view the Mission program as serving more verbal, less disturbed persons and providing flexibility for clients who come and go in a group as needed. In contrast the groups at Rainbow are more structured; groups establish a "group plan" and develop goals for the grcup and groups are not open at all times for new members.

It is possible for a person to be referred to Rainbow Unit for partial program and still be seen at the Mission Center, but it is infrequently done and requires close cooperation by therapists at the Center.

Admission figures for the Rainbow Unit partial program for January through March, 1977, reveal that there is not a significant difference between patients referred and admitted to Rainbow Unit partial program from Johnson County versus Wyandotte County for adults. However, there is a significant difference between children admitted from Wyandotte County versus Johnson County (Johnson County -0- for the same time period Wyandotte County -13). It must be added that for both adults and children the bulk of the admissions come from the Rainbow inpatient, again supporting the statement that the partial program is being used as a transition from the inpatient setting to the community.

The Rainbow Unit Task Force concludes that the partial program at the Rainbow Unit is not being utilized to full benefit, particularly by the Mission Center which has a Day Activity program of its own. While some clients who may be eligible for the partial program are apparently being retained at the Mission Center for

their Day Activity program, there are other significant road blocks to the full usage of the Rainbow partial program. Firstly, it appears that Mission staff are not well informed as to how to use the Rainbow Unit partial program, exactly what it is, and who can best be served by it. Rainbow staff feel that Mission only refers those persons for the partial program who are functioning extremely poorly. Apparently the bulk of Johnson County persons admitted to the Rainbow Unit partial program have come through the inpatient route. In addition, the partial program is held at the Rainbow facility, with the same staff and activities provided to inpatient persons. Apparently some members of the community see Rainbow as strictly inpatient and are not aware of the details of the partial program.

Furthermore, transportation is a significant factor to limited usage of the partial program. This is true for Wyandotte County resident and both adults and children in Johnson County. Centers are hesitant to refer clients with long distances to travel. Rainbow staff is acutely aware of this problem but has been unsuccessful in eradicating it. It is reportedly a priority for next year. A major road block to successful transportation to the Rainbow partial program is the reluctance of SRS to interpret regulations stating that a welfare recipient can receive cab fare reimbursement for medical appointments as applicable to the Rainbow Unit partial program. Administrator Jack Southwick claims that in rare instances persons attending the partial program have been reimbursed, but it requires an individual request and a persistant applicant. Therefore, we urge close co-operation with SRS administrators as to interpretation of the regulations to include attendance at the partial program as a justifiable expense.

According to the Mission Mental Health Center staff, Johnson County has had trouble getting children admitted into Rainbow Unit's partial program on occasion due to lack of space. Apparently some persons hesitate to use Rainbow Unit's program if the child cannot be admitted to the school program. There is little use of the after school program by Johnson County Mental Health Center people. Again transportation is a problem.

The partial program at Rainbow Unit is reportedly planning to take new directions in the next year or so. They intend to present a program which will be available to young persons who have experimented, or are using drugs but are not heavy street users. There will be a special emphasis on young persons. In addition, Rainbow Unit intends to emphasize treatment of younger children who are in their own schools but need more treatment than special education. These children will come in the late afternoon and early evening and their families will receive treatment (1-2 nights per week) in addition to the treatment the children are receiving. The third area in which the Rainbow Unit intends to specialize is in work with geriatrics patients.

Conclusions: In order for the community to better utilize the partial program at the Rainbow Unit and to prevent duplication between the Mission Center Day Activity Program and the Rainbow Unit partial program, it is recommended that the following occur:

1) That representatives from both the Mission Mental Health Center and Rainbow Unit get together to educate one another about specifics of each program, type of client served, means of coordinating between the two, means of referring, and means of preventing duplication. This will be done in an effort to educate all staff, and encourage cooperation and utlization of both programs when necessary.

2) Improve transportation to both programs. This has been mentioned numerous times as a significant peoblem and should be regarded as such by administrators of all facilities.

3) Education of staff at Rainbow Unit and Mental Health Centers as to the uses of Rainbow Unit's partial program as an alternative to hospitalization. Consideration of the partial program by Rainbow Unit staff as a possible alternative for every referral from the community.

4) Follow-up; again greater cooperation is recommended for staff of all facilities as the goal is quality of patient treatment at all facilities, smooth transition between facilities and close cooperation when more than one facility is involved at any given time. This requires a close awareness of the patient and his/her needs as that person receives services at various facilities in the community.

REPRINT FROM:

HEARINGS
BEFORE THE SUBCOMMITTEE ON
PUBLIC HEALTH AND ENVIRONMENT
OF THE COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS — First and Second Sessions
on National Health Insurance and Health Care
December 10, 11, 12, 13 and 14, 1973; February 1 and 2, 1974

STATEMENT OF AL W. TIKWART, JR.

Mr. TIKWART. Yes, sir; and a taxpayer.

Mr. ROY. And a taxpayer, right.

We would welcome your statement, Mr. Tikwart.

Mr. TIKWART. First, I would like to thank you gentlemen for this opportunity. I probably won't be as polished because I don't have the facilities at my command, as do the large organizations that have appeared on the panel. I would like to present some facts that affect the middle American.

Health care costs are too high for the average American. If you would kindly look at attachment 1, gentlemen, I have taken three incomes per hour, $5 per hour, $10 per hour, and $48 per hour. The $5 income is $10,400 per year; the $10 is $20,800, and the $48 is $99,000 plus.

The taxable income on the first man would be $6,000; on the $20,000 man, $15,000; on the $99,000 man, $84,000. I am assuming a 12 percent standard deduction, also that this is an average family of 4 dependents, filing a joint return. The Federal tax for this person of $5 per hour amounts to $1,028. His net after that, gentlemen, is $5.124; the net per hour is $2.46. I have used taxable income less Federal tax to represent one possible type of net spendable income. One could use other statistics such as the U.S. Department of Labor cost of living to arrive at a net spendable income.

The person making $20,000 per year, his net per hour is $5.87.

The person making $48 per hour, his net is $23.41 per hour.

How many hours would it take of work to pay a $15 bill? You know, the average cost in this city ranges from $10 to $25 for an office visit that takes 5–15 minutes of the doctor's time. $15 for the man making $2.46 per hour would be 6 hours of work; for the man making $20,000, it is almost 3 hours of work; for the man in the $100,000 bracket, it is 38 minutes.

What if an individual would have a $5,000 medical bill that is not covered by insurance? I have gone through the tax ramifications, and it shows that for the man earning the $5 per hour, his earnings now would be $1.55 per hour for a year's work. The man earning $20,000,

his earnings are $4.22 per hour; and the man at $100,000 is $22.92.

With this $5,000 bill that could occur—and this amount is not uncommon. We've had two boys in the last 4½ years, each of whom has required surgery and $5,000 is a realistic figure for surgical and hospital care. For the individual earning $5 an hour, the government pays about $838 out of the taxes; the individual pays almost $4,162.

The $20,000 a year man, the Government pays the big sum of $1,098 and the individual pays $3,920.

While the man in the $100,000 bracket, $1,424 is paid by Government taxes, well, it is almost $2,700, and he pays only $3,576. This is less than the man earning one-ninth of what the $48 man earns.

We have a tax inequity here. Once again it shows that our income tax system is very progressive for the middle class but regressive for the rich $100,000-year man.

Why have medical costs increased? I feel that there are two reasons for this.

First off is the great demand for services in a field which was already a seller's market, while the supply of doctors has increased very little. This increased demand was brought about primarily by Government social programs such as medicare and medicade.

No. 2, I also believe that the present system of private insurance, such as Blue Cross and Blue Shield, also have added greatly to the cost. This is due to the fact that doctors, the people who control the supply, serve as members of these boards. We have heard today from the Blue Cross representative the exact figure, a 50–50 ratio—50 percent doctors–50 percent public. I wonder what the census is on the public's portion of these boards? How many people are the young persons, you know, 20, 21, how many are the young married, the young family men on these boards? How many are the retired-type people? These are the persons who bear medical expenses and I question that they are proportionally represented on these boards which are so influential in setting medical fees.

But I know as soon as a certain percentage of the doctors in a community charge a fee for a given service, then Blue Cross-Blue Shield automatically raises the payment for that service. This shows little regard, I believe, for the true supply-and-demand situation.

How can we keep this spiraling cost of medical care down? I believe that it could be done primarily by training more general practitioners, adding to the supply.

Where would we get the money to do this? I believe that one practical solution to this question would be to see that the State and the Federal Government are repaid for the $16,000 to $26,000 average per student per year for medical education. This figure was obtained from a study done by the Association of American Medical Colleges, the professional organization that represents the Nation's 114 private and public medical schools. The article appeared recently in the Kansas City Times, Thursday, October 11, 1973, see attachment 2 [p. 562].

I believe that a doctor, whose education prepares him to be in the top percentiles of income earners in the United States, should pay back the portion of his education cost borne by the taxpayer. No other field, law, engineering, social sciences, tradesmen, plumbers, any of us, is so heavily subsidized, and in no field is the remuneration so great so quickly.

I have worked in the medical-dental consulting field, and I have studied between 75 and 100 practices, both rural and urban in Kansas and Missouri. It is common for a new doctor in his first year to have a net income after expenses of $30,000 to $40,000; also after a short time, a period of 3 to 5 years, practices of $80,000 to $150,000 net per man are common, and I could go on.

If each new doctor would be required to pay directly, in dollars or services, the approximately $80,000 taxpayer-paid portion of his educational costs, a sizable pool could be created.

For example, in the State of Kansas, medical tuition is about $800 per year. I have had a hard time trying to obtain these figures from local officials at K.U. Medical Center. But this is the figure that I was told was correct. Other medical schools in the area, public and private, range from $3,800 to $5,000. Assuming the difference between the student tuition of $800 in Kansas and the cost of medical education stated earlier, taxpayers are bearing a $20,000 subsidy per medical student per each year a student is in medical school. We, in Kansas, subsidize the education of people to enter the top percentages of income.

Yet, if each year the 100 graduates of the K.U. Medical School would pay $10,000 a year for the first 8 years of their practice, a fund would grow to become a living endowment of many millions.

If you look at my attachment 3, it shows that within 8 years, gentlemen, you could have a fund of $8 million that would perpetuate itself a living endowment. If these figures are correct, the $20,000 per year cost to educate a doctor we could triple the enrollment at K.U. and get three times more doctors into the supply and take care of this demand, but to look at demand without meeting the supply of doctors, we are kidding ourselves.

Now, if a doctor would elect a career other than private practice, such as public health service, or public research, public teaching, credit toward this debt to the State could be given.

I would question some things that came up in testimony by the providers. First, I know that doctors, like any student, are in debt when they graduate. The figure of $25,000 to $50,000 was thrown out. You know, gentlemen, there is a tax loophole called income tax averaging which, if used by a doctor, within the first 6 or 7 years, that his tuition costs, and then some, can be paid back again out of tax savings from income averaging. So I don't think it is an idea of just doctors living less years. I think we poor middle-class Americans who are working harder and trying to meet our obligations in a good honest way are the ones who are going to live less, and we don't have $100,000 incomes to afford medical care.

I am sorry for a little bit of emotionalism here. I wanted to keep my talk more on an intellectual plain.

I thank you very much for this opportunity to present my views. In conclusion, I would like my three attachments to be made an official part of this testimony. Also, I would like to say that the local TV, radio, and press—Kansas City Star and Times, gave very little or no advance coverage of this important public meeting on national health insurance. I called local stations and press and they said they had the release but could give no reason why they did not give this meeting coverage. I would also like to go on record and thank station WIBW in Topeka for alerting me of this meeting. This is one radio station that can be counted on to give in-depth news coverage. Thank you. again.

[The attachments referred to follow:]

Attachment 1.

WAGE EARNER, MARRIED, 4 DEPENDENTS, FILING A JOINT RETURN

	$5 per hour, 2,080 hr per year, $10,400 per year	$10 per hour, 2,080 hr per year, $20,800 per year	$48 per hour, 2,080 hr per year, $99,840 per year
Less standard 12 percent	−$1,248	−$2,496	−$11,980.
4 dependents: 750 times 4 equals $3,000	−$3,000	−$3,000	−$3,000.
Taxable income	$6,152	$15,304	$84,860.
Federal tax	−$1,028	−$3,086	−$36,159.
Net (1 form of net spendable income)	$5,124	$12,218	$48,701.
NNet dollars per hour per year	$2.46	$5.87	$23.41.
How many net hours of work equal $15	6.09	2.55 hr	0.64 hr or 38 min.
Tax income	$6,152	$15,304	$84,860.
$5,000 medical bill	−$5,000	−$5,000	−$5,000.
3 percent of tax income	+$184	+$459	+$2,546.
New tax income	$1,336	$10,763	$82,406.
New tax income	$1,336	$10,763	$82,406.
New Federal tax	−$190	$1,988	−$34,735.
New net spendable income	$1,146	$8,775	$47,671.
Net dollars per hour per year	$0.55	$4.22	$22.92.
How many new net hours of work equal $15	27.27 hr equal 3½ days.	3.55 hr equal ½ day.	0.65 hr, or 39 min.
Original Federal tax, no medical deduction	$1,028	$3,086	$36,159.
New Federal tax with $5,000 medical deduction	−$190	−$1,988	−$34,735.
Government pays	$838	$1,098	$1,424.
Individual pays	$4,162	$3,902	$3,576.
Total medical expenses	$5,000	$5,000	$5,000.

Attachment 2.

[From the Kansas City Times, Oct. 11, 1973]

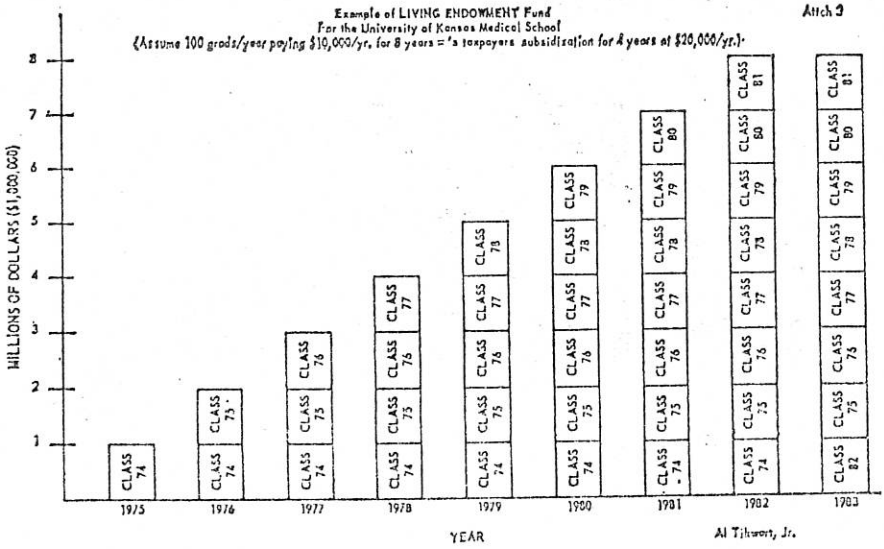
Cost of Medical Education Figured

WASHINGTON (AP)—The first survey of its kind suggests that it cost from $16,000 to $26,000 a year for the medical education of an American doctor.

That adds up to between $64,000 and $104,000 for a 4-year course.

A special committee of the Association of American Medical Colleges, the professional organization that represents the nation's 114 private and public medical schools, made the report.

Students themselves pay about $2,200 a year in tuition. The rest of the cost is paid by federal, state, local and private funds.



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Need more doctors at less expense

by Jim Durlin

Have you recently wondered why your medical costs are sailing out of your budget? And the fact that no matter where you go, the price difference for medical services varies so little?

Take the field of opthamology, as an example. When was the last time you had your eyes checked? A random survey of a dozen opthalmologists in the greater Kansas City area designed to find out what the cost would be for a basic eye examination, showed nine out of the 12 physicians called were charging $30. The other three were $31 or $32. There is not much of a price difference there.

None of us are pleased about spending 20 per cent of our income on medical costs - but from 17-28 per cent of an average family's gross earnings are going to pay his health bill. And 8.4 per cent of the gross national product of our country is spent on health care.

Physician's fees increased 50 per cent faster than the economy as a whole in 1974. And their fees also surged three to four times greater than all other services in 1975. Also, Blue Cross expects a 12 per cent fee increase in doctors' charges in Kansas in 1977.

Some doctors will use the excuse that malpractice suits have increased tremendously, and so have physicians premiums. Insurance premiums have increased, it's true, but they do not justify the tremendous increase in doctors' fees.

The "malpractice crisis" is real, but only a small percentage of the nation's doctors have suffered economic hardship from the malpractice situation, according to a study completed by Medical Economics magazine (December 1976).

Medical Economics said that malpractice insurance had increased 58 per cent in a single year, but pointed out that an increase from $1,500 to $3,000 a year is harmless considering doctors' salaries. And even with the increase, malpractice insurance for most physicians still represents no more than three per cent of gross receipts - hardly reason to justify the 13 per cent average increase in doctors' fees in 1974, and the further hike of 12 per cent in 1975.

But yet in no other profession outside the medical field, is the education of its practictioners so heavily subsidized. And in no other field, law and engineering included, is the remuneration so great, so quickly. After a short period of three to four years, physicians' practices of $150,000 a year are common.

When doctors are making this kind of money, why is it they pay only a fraction of their education costs?

In a 1973 in-depth study of medical colleges, performed by the medical schools themselves, it was discovered that it cost between $61,000 and $104,000 to educate a medical student. But the student usually pays only about $8,800 of these costs and in Kansas the student pays $4,400. The taxpayer picks up the rest of the cost.

The taxpayer is then forced to turn around and pay the physician-inflated fees.

Al Tikwart, Westwood Hills mayor, has had a plan for some time intended at making medical students more responsible financially for their own tax-subsidized education, as well as providing more physicians at less public expense and directing them to areas of highest need.

Tikwart's idea stems on the prospect of increasing tuition costs for medical students from an average of $2,000 a year - to $20,000 a year.

The student could receive an interest-free loan from a state managed living endowment fund, and upon graduation, the student would have an option for repayment of the loan.

The graduate could spend four years in some high-need area of the state he was educated in (there are two counties in Kansas with no physicians and only six out of 105 counties in the state meet suggested national health care standards) in exchange for having the entire loan forgiven. A credit of $80,000 for a doctor working in an area where he will be of greatest service, seems reasonable.

But doctors are hesitant about working in rural areas for a number of different reasons. There are tremendous job pressures in rural areas because the doctor is essentially on 24 hour call, since he is usually the only physician. And the cultural advantages of the city seem to draw more doctors from rural areas. There is plenty of money for doctors in rural areas, but no place for them to spend it. And the education for the physicians' children is usually much better in the cities. The cultural advantages and a more active social life keep doctors in the city.

An alternative is, the physician could work wherever he wants and pay back the full $80,000, and he would have 8 to 10 years to repay the loan.

"With loan repayments in full," says Tikwart, "the money could go back into the living endowment fund to help future medical students obtain an education."

Tikwart said the big problem of increasing medical costs is, "the great demand for services in a field that was already a sellers market, while the supply of doctors has increased very little."

Tikwart said his tuition increase idea would not only increase the supply of doctors, but it would provide physicians with a motive to practice in areas where they are desperately needed.

"If doctors could make five times as much as anybody else legitimately, it would make me feel more comfortable," says Tikwart, "but the prices they are receiving is not a true reflection of a natural price derived at through supply and demand forces."

"And the main reason doctors are receiving such unrealistic prices for their services is the American Medical Association," according to Tikwart.

AMA is a powerful organization that in the election of '72 gave more money to the re-election of Richard Nixon, than any other group, including the Teamster's Union. And the AMA is also the leading giver to congressional races.

The millions spent by the AMA in the presidential and congressional races, Tikwart suggests, could be diverted in researching quality alternatives to the problem of rising health care costs.

"This would be a public service and could help reverse the present negative image of the AMA," Tikwart said.

"The AMA, in most every sense, is as guilty as any group of price fixing," he added. "Historically, the AMA has a way of buying legislation."

The American Accademy of General Practicioners spoke at the Republican platform in Kansas City last August and requested a uniform fee for similar services for physicians throughout the country. Imagine what would happen if the unions or farmers or businessmen requested uniform fees for their employes throughout the country?

A nationalized health program would be a disaster according to Mayor Tikwart.

"We have to have an alternative to a national health program," he said. "National health insurance would be a rip-off and would only make the medical labs, medical equipment manufacturers, doctors and medical insurance, and other cost-plus groups, richer."

"Health care is one of the big four or five economic pillars of our government," the mayor added. "If it goes socialistic, as would be the case with nationalized health, we'd be well on our way toward socialism."

Tikwart does not want socialized medicine, instead he wants, "to be able to afford quality health care for myself and my family."

"I'm sure my plan (increasing tuition costs) to provide more physicians, at far less public expense, and to direct them to areas of greatest need, would work," said Tikwart. "I believe something has to be done soon. I'm tired of being a middle class citizen paying at both ends. And I'm sure I'm not alone."