Any remainder would be allotted in the form of supplemental grants to institutions or groups of institutions in amounts determined on the basis of enrollment. An institution would be required to match the federal money and not to reduce its annual expenditure for libraries.

The other 25 percent would be used for special-purpose grants to institutions that demonstrate a "special need" for added library services and show promise that the expenditure would improve the quality of educational services.

Another $15 million would be available to support training in "librarianship" and also to finance research and demonstration projects to improve libraries or the training of librarians.

Finally, $5 million was added during subcommittee consideration of the bill as a gesture essentially toward encouraging the establishment of research libraries. The money would be transferred to the Library of Congress to be used for speeding up its cataloging services. Funds could be used to acquire scholarly materials from anywhere in the world, to expedite the cataloging process after receipt of the materials, and to facilitate the exchange with other libraries of materials not needed by the Library of Congress.

The big increase in money in the new bill over the original comes in the authorization of an additional $230 million in grants for the construction of undergraduate facilities and $60 million for graduate facilities. These are increases above the $460 million and $60 million for undergraduate and graduate facilities already approved by the House in the Higher Facilities Education Act for the fiscal year which began on 1 July.

A noteworthy innovation in the bill, reportedly incorporated mainly on the urging of Mrs. Green, is the provision of an advisory council to the Committee on Education and Labor "to make studies or recommendations" on programs established under the act. The Executive agencies have until now had a monopoly on advisory councils. By creating one of its own from among experts who are not government employees the committee could be setting Congress an example in narrowing the gap in expertise between the Executive and Legislative branches.

While it is still being assumed in Washington that a higher-education aid bill will be passed during this session of Congress, there is cause for uncertainty as to what form it will take.

President Johnson publicly gave higher-education legislation a high priority last month, and this was interpreted by some to mean that his prestige and persuasive powers would be deployed in behalf of the bill now emerging from the House committee.

But the Senate appears bent on adding major provisions to the measure, such as a revived GI Bill and establishment of a "national teachers corps" to serve in low-income areas (the President last week espoused this idea in a speech at the National Education Association convention in New York).

A bill combining House and Senate provisions would probably turn out to be too expensive for the Bureau of the Budget to accept or the Congress, under normal circumstances, to approve. Furthermore, when, as seems inevitable, representatives of the House and Senate meet in conference to reconcile differences over their respective versions, it appears certain there will be conflicts on such points as the degree of emphasis to be placed on urban and suburban problems in the community-service programs.

The circumstances, therefore, are quite different from those which prevailed when the Senate earlier in the year accepted the House version of the school bill, thereby avoiding any unpleasantness or delay. This time reaching a meeting of minds is likely to make the legislative summer seem longer and hotter.—JOHN WALSH

The Doctors' Debate: What To Do When Medicare Comes Is Main Topic at Stormy AMA Session

For about 20 years the American Medical Association has been campaigning intensively against federal medical insurance tied to Social Security. In the course of the fight the association has spent millions of dollars, alienated itself from substantial portions of the medical and scientific communities and the general public, and, in the opinion of many observers, downgraded itself from a professional society to little more than a trade association or lobby. Now, with the passage of a medicare bill drawing closer and closer, the association is facing a major defeat, and as the doctors gathered in New York a few weeks ago for their 114th annual convention, the atmosphere of gloom resembled nothing so much as descriptions of the French at Dienbienphu. The mood of the meeting was well caught by the medical reporter who circulated around the press table a bogus account of the deliberations which began: "New York, June 21—Seven dentists yesterday responded to an emergency call from the American Hotel here, promptly treating 43 physicians for a condition called 'bruxal fracture.' The doctors had broken their teeth by gnashing them." Teeth-gnashing, breast-beating, and wailing were indeed the order of the day.

Medicare and the Doctors

Why the doctors so fear medicare is by no means an easy question to answer. To the leadership of the AMA, the elected and appointed officials based in Chicago, the issues seem essentially threefold. First, they do not believe that the medicare bill passed by the House in April and approved by the Senate Finance Committee 2 weeks ago is necessarily the best way of getting medical services to the aged individuals who need it most. Second, they believe that concern over the costs of the program will inevitably lead the government to take a more active role in determining what medical services are dispensed, and how they are dispensed. And, finally, AMA leaders believe that the specific bill in question already provides the specific vehicles for eventual government control over medical practice.

The adequacy of the protection afforded by H.R. 6675 is indeed open to question (see box). The string of deductibles under both the compulsory and the voluntary supplemental plans, together with the limitation on duration of hospital or nursing-home stays, make it probable that the very poor and the very sick will still have difficulty paying their bills. Senator Russell Long (D–La.), who made an unsuccessful effort in the Senate Finance Committee to eliminate the ceiling on hospital stays and scale the payments required of a patient receiving services to ability to pay, was recently quoted as saying that the bill provided "free care for the millionaires who can afford it." (The House version requires a flat payment of $40 for 60 days of hospital care; the Senate version adds an additional 60 days, with the patient paying $10 per day toward the costs.) Despite the bill's gaps, however, it is unlikely to make medical care any worse for the impoverished elderly, and is quite likely to improve it. In addition, the fact is that no one has yet produced an alternative plan likely to do the job better on a remotely reasonable financial

scale. After years of unproductive opposition—and only when the Democratic landslide and the relaxation of the long-standing opposition of House Ways and Means Committee chairman Wilbur Mills (D–Ark.) made passage of medicare a likelihood—the AMA last winter introduced a plan of its own, dubbed "eldercare," for which it waged a blitzkrieg campaign. But, while "eldercare" opened the possibility of coverage more comprehensive than that of medicare, by leaving key options to the states, it also opened the possibility that some states would choose to provide no, or little, coverage. This inequity among states has been a key factor in creating dissatisfaction with the current Kerr-Mills program of federal support for state health plans. The only other plan that has been seriously offered was proposed by Representative John W. Byrnes (R–Wis.) last winter. With some modifications, the Byrnes proposal was incorporated into the administration bill as the voluntary or supplemental portion, which provides payment for physicians' fees and other costs incurred outside the hospital. Few in the government or out are arguing that the medicare bill is perfect. But most observers feel that medicare in its current form is the best insurance plan that has been offered.

While AMA objections to the adequacy of medicare appear to be in some measure intellectual, worry over the probability of federal control seems in large part visceral. The bill provides that "nothing . . . shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided. . . ." But the AMA believes that alarm over the costs of the program (which they predict will be higher than the $4½ billion per year medicare supporters now estimate) will inevitably drive the government into evaluating, proscribing, and generally affecting the relation of the doctor to his patient. The AMA does not say that government control will begin now, or that anyone consciously wants it to happen, just that the potential for control is there, and federal involvement probable.

There are several specific points cited as grounds for foreboding. One is the requirement that physicians certify that hospitalization or admission to a nursing home was medically required, and why. Another is a provision that each hospital and nursing home maintain a utilization review committee, to review hospital admissions, durations of stay, and professional services furnished. On both of these points the intent of the bill is chiefly to prevent the overuse of facilities that could plausibly occur with widespread insurance, and—to put it more crudely—to make sure the government is limiting its payments to necessary services. Comparatively few

BILL PROVIDING MEDICAL CARE FOR THE AGED UNDER SOCIAL SECURITY

Main Provisions of the Medicare Bill As It Came Out of the Senate Finance Committee, with Principal Changes from the House Version Noted

Basic Health Plan

All of the 19 million persons 65 and over would be covered, 16.4 million under Social Security, 600,000 under railroad retirement, and about 2 million others, for whom cost would be paid from general Treasury funds. These costs are estimated at about $200 million a year at the outset.

Benefits under the Senate plan are estimated at about $2.4 billion in the first full year, and Social Security taxes allocated to the plan are estimated at $2.6 billion.

Under the House bill, 60 days of hospital care for each illness would be provided, with the patient paying the first $40. A beneficiary would be eligible for an additional 60 days after he had been out of the hospital 60 days. This could include treatment for mental illness, but there would be a 180-day lifetime limit on such treatment (under the Senate bill, 210 days).

The Senate bill would add an additional 60 days of hospital care, but the patient would have to pay $10 of the cost of each extra day.

The House bill includes a maximum of 80 days of nursing-home care after a hospital stay. A patient would be eligible for 20 days' care plus 2 additional days for each day that his hospital stay was short of 60 days, up to a maximum of 80 additional days.

The Senate bill changes this to provide a maximum of 100 days, but the patient would pay $5 of the cost of each day beyond 20.

The House version provides for post-hospital home health services up to a maximum of 100 visits by a nurse for each illness. The Senate bill would increase this to 175 visits.

Both measures provide outpatient hospital diagnostic services. The patient would have to pay the first $20 of such services furnished him during a 20-day period. Under the Senate bill, he would also have to pay 20 percent of the cost of the services above the $20 deductible.

The plan would be financed by a payroll tax placed in a separate hospital insurance fund. The levy would be 0.325 percent each on the employee and the employer, or on the self-employed individual, in 1966; it would be increased to 0.50 percent in 1967 and to 0.80 percent by 1987. Under the House bill the taxable wage base would be $5600 in 1966, rising to $6600 in 1971. Under the Senate bill it would be $6600, starting next year. It now is $4800.

All of the benefits would become effective 1 July 1966 except for the nursing-home care, which would begin 1 January 1967.

Supplemental Health Plan

Enrollees would pay $3 a month in premiums; the government would match this. The Administration estimates that 17.5 million of the 19 million persons 65 and over would enroll.

Benefits include:

- Physicians and surgical services in a home, hospital, office or clinic.
- Home health services without regard to hospitalization, up to 100 visits a year.
- Diagnostic x-ray and laboratory tests, electrocardiograms, basal metabolism readings, and other tests outside the hospital.
- X-ray, radium, and radioactive isotope therapy.
- Ambulance services, under limited conditions.
- Surgical dressings and splints, casts and other devices for reduction of fractures and dislocations; rental of durable medical equipment (such as iron lungs, oxygen tents, hospital beds, and wheelchairs) used in the home; prosthetic devices other than dental; braces and artificial limbs.

The plan would pay 80 percent of the bills for the covered benefits above a $50 annual deductible minimum. The patient would pay 20 percent.

Under the House bill, the supplemental plan would take effect 1 July 1966; under the Senate version, 1 January 1967. Premium payments would start on the effective date.

of the individuals eligible for medicare have jobs to which they must return, many live alone in conditions more bleak than those of hospitals, and the desire to stay in as long as possible could easily become a real problem. Many hospitals have already established voluntary review committees to make certain that available space is wisely distributed. But the AMA feels that, in addition to being a nuisance, the certification and review procedures provide a ready route for the government to step in and challenge the validity of physicians' decisions, and that they will lead to standardization of criteria for care that would substitute bureaucratic control for the doctor's own judgment. The AMA, revealing the economic trepidations which many of its critics have suspected underlie all its other anti-medicare arguments, is worried also about the provision that "reasonable cost" for services be determined by regulations worked out with HEW. ("The word 'reasonable' poses all kinds of problems," one official said recently. "Who's to say what reasonable is?") And it is concerned about a provision that only those drugs and biologicals cited in standardized compendia such as the USP or the National Formulary are to be covered by the federal insurance. The principle here seems to be that, although almost all drugs are included in these references, nonetheless the physician shuld be free of any restrictions whatever in his choices. A final point agitating the AMA is the inclusion of pathologists, radiologists, physiatrists, and anesthesiologists under the basic or hospital portion of the plan, whenever payment would normally be to the hospital. This is a feature only of the Senate bill; in the House version, favored by AMA, these services are covered by the supplemental plan, under which payment is to the physician. This particular fight reflects a growing quarrel between the American Hospital Association, which favors extending the definition of "hospital services," and AMA, which wants to restrict it. The AMA holds, as a basic tenet, that medical care deteriorates as the distance between the doctor and the patient widens, and although this is already occurring as the increase in medical insurance makes "third party" intervention increasingly common, the association feels the Senate proposal would accelerate it. The AMA's position is that these specialists are physicians like all others, equally entitled to the privacy of a special relationship with their patients. In addition, the AMA feels that, since the hospital portion of medicare is the part most subject to federal controls, the narrower its jurisdiction the better. Inclusion of radiologists, it is felt, could logically lead to inclusion of gynecologists, pediatricians, and internists, which in turn could lead to a situation where all medical practice would center around hospitals, and private fee-for-service practice would virtually cease.

The House of Delegates

If the leaders of the AMA are at least rational in their criticisms of medicare (whether or not their criticisms are valid) the same cannot be said for the association's House of Delegates which gathered in New York. Eight state delegations and one individual introduced resolutions calling for physicians to boycott the medicare program, and, indeed, the question of boycott—or "nonparticipation"—dominated the entire meeting. The resolutions varied in degree of hysteria, but they were basically all cries of protest against what the doctors regarded as the march of socialism. The Nebraska resolution is fairly typical. It read:

> Whereas, H.R. 6675 contains unnecessary provisions which are socialized medicine; and
>
> Whereas, These provisions cause physicians and hospitals to be under bureaucratic control of the Federal government and unwilling guardians of the Federal treasury; therefore be it
>
> *Resolved*, That it is ethical, proper, desirable, moral and legal not to participate in such socialistic schemes.

Many doctors had been through divisive debates in the state and local medical societies on the question of boycott; many had been pursued by a variety of homegrown doctors' organizations in California and elsewhere which began propagandizing for a boycott several months ago; many had paid their way to New York specifically seeking the opportunity to influence this critical decision. When the opening speech of the AMA's newly installed President James Z. Appel of Lancaster, Pennsylavania, condemned a boycott or doctors' strike as unethical and urged the doctors to participate in the program, resentment was palpable. "Dr. Appel's position is incredible, heartbreaking, unacceptable," a physician from South Carolina burst out during the debate before the legislative committee to which the resolutions were referred. "We would become zombies, stepping into involuntary servitude, if we accept such fascist control." "Dr. Appel has created a schizophrenic frame of mind in doctors," a Kansas general practitioner asserted. "We are having total war waged on us from Washington." In California, a movement for Appel's impeachment began. And in New York, the cries of pain persisted. Medicare is "the beginning of total socialization of this country," said one doctor; "part of the world socialist conspiracy," said another; "basically against the American Dream," according to a third. But when the emotional wave was spent, the move for a boycott was defeated.

AMA Politics

Of the delegates' performance, one AMA official later said privately, "sure, we know it looked awful, and if public relations had been the only consideration, we could have managed a better show. But we had to give these guys a chance to have their say."

How far, in the final analysis, the delegates followed the dictates of their consciences and how much they followed the dictation of their leaders is a somewhat mysterious question. The observable facts are these. The AMA leadership, sensitive to the loss of credibility and influence that its long isolation over medicare has already produced, came to New York opposing a boycott; a substantial portion of the delegates came to New York endorsing one; in the end, the leadership was victorious; and comparatively little rational argument that could explain the change in sentiment was heard in between. But who controlled the decision and what the patterns of influence are—who was flattered by an invitation to which cocktail party or cajoled over a midnight snack—is very unclear. Analysis is made more difficult by the propensity of the doctors to take at face value the assertion that "the AMA is a democratic organization"—a statement equivalent in information to the high school civics text observation that American government has three branches—and their disinclination to regard the ceaseless talking, scurrying, and back-slapping as a form of politics. But that the decision was influenced by the formal and informal links which tie the delegates (independently elected by their state societies) to the national leadership, and that it did not necessarily reflect the views of the majority of dele-

gates present, there can be little doubt.

One level of "management" is strictly personal: members of key committees are chosen by the Speaker of the House of Delegates, who, though elected by the delegates themselves, works closely with the national leaders—the Board of Trustees and their appointed executives. The chances that such committee members would defy the leadership, while not nonexistent, are low.

Another level of management is tactical. One evidence of it was the delay of open debate on the boycott resolution—the moment anticipated as the climax all week—until so late in the convention that many delegates had to leave to check out of their hotel rooms. Another evidence was the fact that when the resolution of the reference committee—which called for taking no action whatever until the bill became law, when a special session of the House of Delegates might be called—was brought forth, it was immediately subject to a lengthy and complicated amendment. From that point on, all debate had to center on the proposed amendment—introduced by a young physician said to be a probable future officer of the AMA—and the anticipated outburst against the moderate stand never had a chance to occur.

Certain ambiguities in the rather tortuous resolution that was adopted make it appear that the doctors have merely vetoed an organized boycott while sanctioning what might be called an unorganized one—nonparticipation by individual physicians. The call to reconvene the House of Delegates when the medicare bill is officially passed would also seem to mean that the boycott movement might be resurrected. But it is the opinion of most observers that these measures are meant chiefly as rhetorical consolation for the boycott party, and that they will have relatively little effect on future AMA policy.—ELINOR LANGER

(The probable direction of the AMA on medicare and other current issues will be discussed in a future article.)

Announcements

Baylor University this fall will begin a 1-year graduate program in **biomedical physics and mathematics**, supported by the National Heart Institute. Emphasis will be on the biological applications of mathematics, physics, and electronics. The program will consist of lectures and laboratory work, with the summer quarter for research in the field of the student's choice. Fellowships are available. Further information is available from L. A. Geddes, Department of Physiology, Baylor University College of Medicine, 1200 Moursund Avenue, Houston, Texas 77025.

The Research Institute for **Skeletomuscular Diseases** of the Hospital for Joint Diseases has begun a training program in basic research methods for orthopedic surgeons and rheumatologists. Studies include connective tissue and steroid chemistry, pathogenesis of bone tumors, and cell metabolism. Fellowships are available for persons who have completed their clinical training. Additional information is available from the director, Vincent Hollander, Research Institute for Skeletomuscular Diseases, Hospital for Joint Diseases, 1919 Madison Avenue, New York)

Meeting Notes

The 11th **Pacific Science Congress,** for the Pacific Science Association organized by the Science Council of Japan is scheduled for 22 August to 10 September, 1966, at the University of Tokyo. About 60 symposiums will be held at which only invited papers will be presented. Papers are invited for presentation during the second week of division meetings. Contributed papers for these subjects should be sent to the secretary of the correct section as listed in the preliminary announcement. These announcements and other information are available from the National Representative Institutions of the participating countries, which include nations bordering on the Pacific Ocean. U.S. scientists should write to H. J. Coolidge, Executive Director, Pacific Science Board, National Academy of Sciences, 2101 Constitution Avenue, NW, Washington 20418. Details are also available from the secretary-general of the congress, Yoshio Hiyama, Fisheries Institute, Faculty of Agriculture, University of Tokyo, Bunkyo-ku, Tokyo. The organizing committee also requests that applications to present papers be authorized by the countries' national representative institutions or by the international scientific organizations with which they may be affiliated.

Members of the AAAS who plan to attend the Pacific Science Congress are eligible for group air travel rates. Members who wish to take advantage of the reduced rates afforded by group travel should write for further information to: AAAS, Room 219, 1515 Massachusetts Avenue, NW, Washington, D.C. 20005.

The fall meeting of the **National Academy of Sciences** will take place at the University of Washington, Seattle, 11–13 October. Symposiums will be held on universities and federal science policies, high-energy physics, and biochemistry and genetics. Contributed papers will be presented or sponsored by members of the Academy. (H. Neurath, Department of Biochemistry, University of Washington, Seattle 98105)

Courses

Lipid methodology will be the topic of a course presented 9–13 August at Pomona College, California. The course is sponsored by the school and the American Oil Chemists' Society. It will present lectures and demonstrations of techniques for isolation, identification, and analysis of lipids. (C. F. Allen, Department of Chemistry, Pomona College, Claremont, California)

Scientists in the News

Wayne State University has appointed **Margaret L. Shetland** dean of nursing, succeeding **Katharine E. Faville.** She is now professor and director of public health nursing at the University of North Carolina.

Charles W. Philpott, assistant professor of biology at Rice University, has been elected president of the new Texas Society for Electron Microscopy.

William C. Knopf, chairman of the department of electrical engineering and chairman of the division of oceanographic engineering at the Institute of Marine Science, University of Miami, has been named dean of the university's school of engineering, effective 1 September. He will succeed **T. A. Weyher,** who has announced plans to retire.

Theodore C. Ruch, chairman of the department of biophysics at the University of Washington, Seattle, has become director of the university's Regional Primate Research Center.