develop methodology for psychosocial support with the same precision that we develop and test methods for radiotherapy, chemotherapy, hormonal treatments, and surgery.

Systematic assessment of outcome and methods is an appropriate standard for the development of medical practice, and it should apply equally to psychosocial as well as biotechnological intervention. Data like that seen in this paper can serve as basis for the rational development of our concept of medical treatment to include systematic intervention for the psychosocial as well as biomedical aspects of illness. Much more research needs to be done, but there is sufficient evidence of efficacy to suggest that we should devote resources to the application of this new knowledge and the routine treatment of cancer patients and others with life-threatening illness.

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Residency Training in Community Health Centers —An Unfulfilled Opportunity

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In 1969, I was invited by Dr. Harold Wise to become the first Social Medicine Resident at the Martin Luther King, Jr. Neighborhood Health Center in the South Bronx, NY, affiliated with Montefiore Hospital and Medical Center. The purpose was to train community-responsive physicians as members of health care teams that already included nurse practitioners and family health workers from the local neighborhood.

The Residency Program in Social Medicine has continued since that time, producing substantial numbers of residents, including significant numbers of minorities, who are now in inner city generalist practices. There are similar examples in other organizations and settings, both rural and urban, State and

Federal, health centers and Indian Health Services facilities, and AIDS clinics. But in general, they remain exceptions to the rule. Very small percentages of even generalist resident time is spent in such settings. Why is this so, and what can be done to change this situation?

There are several categories of reasons, many of which are general barriers to resident training in ambulatory settings. These sometimes include an incompletely developed educational environment as well as community resistance to adding teaching to the clinical mission of the center. One of the most important, however, (which in part explains the others) are the financial disincentives, both for ambulatory practice and for outpatient resident payment. Direct costs of residents are often not covered by public or private payors, and costs of instruction and supervision are even more difficult to support. Given current efforts to improve efficiency through managed care, any decreases in practice productivity must be financed from some source.

At Martin Luther King, this gap was covered by a grant from the Office of Economic Opportunity, which has long since disappeared, although Title VII Public Health Service programs still provide important support for financially fragile institutions. In this issue of *Public Health Reports* on page 312, Zweifler describes a contemporary approach in a Fresno, CA, community health center affiliated with the University of California at San Francisco (*1*). A productivity decline is reported, which varies depending on the experience of the resident. Overall, an additional educational cost of $7,700 per resident per year was identified in this setting.

Such costs will certainly vary across sites with different practice and educational environments, and multisite comparative analysis is urgently needed. Not only do underserved communities lack adequate numbers of physicians, but they lack physicians with some of the special competencies and cultural understanding that these communities need if access is to improve and, more importantly, if the population's health status is to improve.

Similar needs are being expressed by managed care organizations; since managed care is coming to Medicaid and Medicare in underserved areas, the challenge is multiplied.

Although additional financial and training models need to be developed, there is enough potential synergy between the patient care and educational needs in public ambulatory settings for a substantial increase now in these opportunities. One approach would provide better coordination within the programs of the Health Resources and Services Administration (HRSA) and the Health Care Financing Administration (HCFA). Why shouldn't some service delivery dollars in certain community and migrant health center and Indian Health Service programs be set aside to fund the deficits Zweifler describes—and why shouldn't priority be given to those grantees under Titles VII and VIII of the Public Health Service Act that are directly linked to Public Health Service underserved delivery sites?

In addition, serious consideration should be given to upweighting Medicare graduate medical education (GME) time spent in ambulatory care settings (as has been done in New York State) and perhaps double upweighting for time spent in public delivery sites. Similar provisions could be considered for Medicaid regulations or waivers as this program is restructured. It is not widely appreciated that GME payments are built into Medicare risk contract rates, but they are not used directly to support graduate medical education in hospitals, much less ambulatory care sites in underserved areas.

Similarly, self-insured plans (under the Employment Retirement Income Security Act) are not required to contribute to this overall public responsibility. The all-payor pool proposed in 1994 in the Health Security Act and supported by the Council on Graduate Medical Education and the Association of American Medical Colleges would have achieved this goal. In the absence of a national framework, perhaps State networks of academic centers, managed care plans, the State Medicaid Program (and even indemnity and insurers under the Employment Retirement Income Security Act) could come together to form "public-private academic endowments" to support graduate medical education with special attention to public ambulatory settings.

In this era of limited resources, we cannot overlook the opportunity for linking public health care delivery and graduate medical education goals and move the successful anecdotal experiences into mainline national policy and practice.

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