White House Conference on Health

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THE WHITE HOUSE Conference on Health was convened by President Lyndon B. Johnson "to bring together the best minds and the boldest ideas to deal with the pressing health needs of this nation." In calling the conference he stated, "Ours is a great opportunity to advance ideas which will contribute not only to a healthier America, but to a better world. We have the resources; we need only the will and the leadership. Let us raise our sights—and unlimber our imaginations."

Those called to meet that challenge were drawn from the nation's creative leaders in many fields. They represented almost all vocations and points of view: health professionals, administrators, educators, representatives of government, business, and labor, officials of voluntary agencies, economists, writers, and clergymen.

The conference was designed to permit the widest possible latitude to exchange views, with discussion periods arranged so that each person attending could participate. There was no effort to reach consensus or present specific recommendations.

The theme of the opening speeches was unmistakably similar. "Today we aspire and fully intend to make the best health services readily accessible to all who need them," declared Dr. William H. Stewart, Surgeon General of the Public Health Service.

Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, reminded the audience that "many of our citizens do not have available the health services which they need, in a setting and at a time that is appropriate." He called for a partnership of private medicine, the academic community, and the government to achieve the potential of the recently passed health legislation.

Dr. Alderman was a staff assistant for the White House Conference on Health and is now special projects officer, Division of Public Health Methods, Public Health Service.

Health Professions Education

In introducing the set of panels on health professions education, Stewart pointed out that the availability of competent manpower will determine the quality of our health program. He called on the participants to look beyond the old problem of "education for how many?" to the newer one of "education for what?" The quantitative battle may not yet be won, but the issue is fairly joined. The more complex problem, which will require far greater sophistication, is to "tune our training . . . to the changing needs of the people we serve," he said.

Health Manpower Needs

The panel on health manpower needs was moderated by Dr. William N. Hubbard, Jr., dean, University of Michigan Medical School. He reminded the participants of the urgent demands on manpower that rapid population growth, economic prosperity, and medical progress have raised. Rapid expansion of the total manpower pool for health care is required, although it was equally clear that the physician-patient ratio does not completely describe the useful supply of medical manpower. It was noted that Sweden, with 80 physicians per 100,000, has an infant mortality rate less than that

of the United States with a physician-patient ratio of about 150 per 100,000. In this and other sessions it was often said that we must use our existing manpower more efficiently than we now do.

Attention was directed to the declining percentage of college graduates who, though qualified for a medical education, do not now seek it. Yet we fail to comb the reservoir of potential talent among the poor, the disadvantaged, and minority groups for future members of the health professions.

The nation has become aware that the supply of physicians is inadequate and has begun to take steps to alleviate that shortage. The picture in the allied professions (nurses, occupational therapists, rehabilitation counselors, and medical technologists, for example) is not nearly as hopeful. Despite the lip service, too little has been done to develop other members of the team. Programs and facilities available for training persons for these professions are woefully inadequate.

Some participants felt that universities and junior colleges should join with medical centers and hospitals to develop programs in which training and service are integrated.

The utilization of subprofessionals was seen as a potential mechanism to free the professional from tasks others can do, thus giving him time for reprofessionalization.

Trends in Basic Professional Education

In the panel on trends in basic professional education, Dr. Robert H. Ebert, dean, Harvard Medical School, urged participants to examine long-held but often unchallenged assumptions about professional education. Does medical education need to last 4 years? Should all students receive the same education during medical school regardless of their future career plans? Does educational focus on the welfare of the individual patient by the physician insure the best health care for the whole community? Should medical educators continue to ignore the experience of educators in other disciplines?

Members of the panel wondered whether medical education should be limited solely to the period after college. Dr. W. Montague Cobb, Howard University College of Medicine, pointed out that the very young can be exposed to concepts germane to medicine from preschool playing days through grammar and high school. There was a recognition that high school education today was producing students of far greater maturity and sophistication than ever before. Cobb urged colleges and professional schools to take advantage of this new breed by instilling flexibility into their curriculums. He urged that they be encouraged to get into the heart of subject areas as soon as possible by reducing required curriculums to the minimum.

Many participants were concerned about the myopia which limits the focus of medical education to the physician and hospital, rather than on the community and patient. Dr. Leona Baumgartner, former commissioner of health, New York City, suggested that it was time to examine the community, detect the kinds of services people need and want, and then tailor educational systems to produce people able to provide those needed services. A training system designed 50 years ago can hardly be appropriate to the rapidly changing needs of an urbanized industrial society.

Responsibility for Teaching and Research

The panel session on the responsibility for teaching and research, moderated by Dr. Eugene A. Stead, Jr., Duke University School of Medicine, dealt with the problems of producing clinicians in a system where research is co-equal with teaching. Many felt that the medical school curriculums were often too rigid and that the pattern was hard to break because of the vested interests of the various faculty members. Teachers and their students often maintain the same professional roles throughout a lifetime, while tremendous changes in biomedical knowledge are occurring. This pattern of professional rigidity must be broken, it was emphasized.

There was a demand that the medical center organize exploding medical knowledge and transmit it to the community's physicians. Computers able to codify and deliver information should be used to assist this process.

Stead's comment that physicians need time—time to think, to study, to observe, and to listen—struck a responsive chord in the audience.

Concern was expressed that the emphasis on research has possibly distorted the traditional

balance of the medical school program. Means must be found to integrate investigators and their research into clinical teaching. This should strengthen both research and teaching.

The particular role of the specialized research institute was discussed by Dr. E. Grey Dimond, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation. The freedom from group responsibility permitted the institute investigator was contrasted with the requirements for faculty participation in a traditional academic environment. Freedom from teaching permits unfettered pursuit of research goals. Independent financing was seen as a particular advantage, allowing greater freedom of action in the specialized institute. Insulation from the educational system was viewed as a principal drawback. A heavy commitment to graduate education might help to rectify that academic isolation.

Frequently in this panel, as in others, the comment recurred that new kinds of health workers were needed. There is a need to bridge the gap between the various professionals and the patient, as well as to expand the range of present-day health services. There was recognition that so far we lack even the techniques to identify such roles, much less devise educational programs for them. Considerable research into the definition of roles would be required.

Trends in Continuing Professional Education

A panel moderated by Dr. Clark Wescoe, chancellor of the University of Kansas, tackled the thorny dilemma of postgraduate training. Underlying all the discussion seemed to be an awareness that the dynamic advances of modern medicine and the exploding demand for the newest and best in health care imposes an urgency on educators trying to perfect techniques of continuing education that insure renewal of medical manpower. Unless such a system can be made to work, the rapidly accelerating rate of medical obsolescence will always limit the quality of medical care; we will never truly be giving the patient the best of today's medicine. We will not even be giving him the best of yesterday's medicine, because the out-of-touch practitioner naturally forgets some of what he once knew.

The hospital, as the traditional focal point of practice, was recognized as a logical center for such programs. Private physicians should be involved in planning education to suit their needs and wants. Likewise, the medical school and university have a commitment to put their best efforts into postgraduate programs.

The goal for continuing education is participation by all physicians. Widespread programs already attract a substantial percentage of U.S. physicians, but these programs are of varying quality. We need to know more about how to run postgraduate courses. We have to discover what techniques work, and therefore we must develop criteria for evaluation.

The shameful barring of Negro physicians from hospital appointment was seen as not only a moral disgrace, but also an unfortunate way of keeping some physicians, and their patients, from sharing in medical progress.

Some participants suggested a program of continuing education coupled with examinations, or, alternately, an incentive program for continuing education such as that of the American Academy of General Practice. One speaker urged that the formal 4-year association of student and medical school be discarded. Each physician should be a lifetime student. He would always be subjected to academic stimulus, and the medical school would be encouraged by the physicians of the community to adjust programs to meet the community's needs.

Throughout the panel, the theme was clear: the tools acquired during formal medical education all too quickly become obsolete and, therefore, continuing education is mandatory.

Role of Allied Health Professions

Dr. Vernon W. Lippard, Yale University School of Medicine, chaired the panel on the role of allied health professions. He emphasized that the growing shortage of health manpower makes it imperative that existing manpower be utilized in the most efficient way. Lippard set the tone for the group by stressing the importance of a team approach to health care, a team which really functions, with the physician as boss.

It was clear that more personnel at the semi and nonprofessional level, as well as the professional level would have to be developed

Dr. Leonard J. Duhl, National Institute of Mental Health, Public Health Service, pointed out that health care ought to be a part of any community renewal program. He noted the Peace Corps experience in which a limited number of medical personnel were effectively used to train all Peace Corpsmen to participate in health care. This should be done in our own communities. Health education programs in the schools should be improved. Nonprofessional health aides, drawn from the community at large, should be involved in bridging the gap between the physician and the patient.

Physicians and other health professionals, such as nurses, occupational therapists, physical therapists, and technicians should have more time to attend to their patients. But regardless of the success of efforts to more efficiently use their talents, an enormous expansion of the allied health professions will still be required if we are to actually provide the services that are available to help the patient.

Economics of Health Professions Education

Dr. Ward Darley, Association of American Medical Colleges, led the panel on economics of health professions education. He pointed out that funding of professional education was reaching a critical point. The recent dramatic increase in financial support for sponsored programs in medical schools has now surpassed the total of general, noncommitted funds directly controlled by the medical schools. Funds for sponsored programs usually require supplementation by the university and the medical school. Since the noncommitted resources are not expanding nearly as fast as the sponsored funds, the medical school will soon be unable to accept outside sponsored funds and still perform its proper function.

There seemed to be agreement with the plea of Dael Wolfle, American Association for the Advancement of Science, for an increase in funds controlled by medical schools to assure the freedom to innovate as well as to support balanced growth of the medical institution.

Some felt that existing medical schools should expand, albeit modestly, to meet the growing shortage of physicians. Furthermore, some way must also be found to utilize the manpower resources represented by the medical school applicants who fail admission but are qualified and motivated to contribute to the health enterprise.

Funding medical student training is still beyond the means of most students. The legislation of the 89th Congress was regarded as a fine first step to solve that problem. The economic impediments to entrance to medical school simply had to be overcome to avoid the greater cost of wasted talent.

A spirited plea was made for medical school deans to assume leadership in planning for medical school growth and development in the future—one speaker said that means "taking the lead away from Congress . . ." He said in recent years congressional committees had done more to plan the growth of health care than had medical education leaders.

Health Care

A series of six panels were devoted to determining what health care for Americans ought to be. In setting the stage for the panels, Dr. Michael E. DeBakey, Baylor University College of Medicine, pointed out that new knowledge is the wellspring of better health. "The cycle of scientific inquiry—new knowledge—improved human service is . . . self perpetuating." He continued, "as society continues to demand that new discoveries . . . be translated into practical use, this conversion will require even more and better personnel, facilities, and equipment."

James Z. Appel, president, American Medical Association, emphasized that the association was vitally concerned with the present inadequacies of medical care, "to state the matter in its baldest terms, our present medical care, fine as it is, is not good enough . . ." He pledged the support of the AMA in the nation's quest for better health. Dr. Philip Bonnet, president of the American Hospital Association, spoke of the changes wrought by scientific progress in the patterns of patient care and described the implications these changes have for hospitals.

Through all the speeches, and the later panel sessions, ran the theme that our problem was to convert the very best care we know how to deliver from a privilege of the few to a right for all. What we do for the disadvantaged,

primarily the poor and the Negro, will represent the measure of how well we translate that resolution to reality, as Dr. Alonzo Yerby, commissioner of hospitals, New York City, said, "so that the poor will no longer be forced to barter their dignity for their health."

New Knowledge and its Application

In a sense, the title of the panel session, new knowledge and its application, epitomized the whole conference. Dr. Thomas Hunter, University of Virginia Medical School, urged that, in our zeal to speed the application of new knowledge, we resist the temptation to slight research efforts. He called for continued Federal support of medical research through the National Institutes of Health of the Public Health Service.

It is increasingly difficult to translate the products of medical research into improved health care. Rising public expectation of ever greater accomplishments sometimes encourages the short-cutting of traditional safeguards. Professional judgment already has to balance legitimate popular demand for the latest technology with a healthy caution.

Dr. James G. Miller, Mental Health Research Institute, University of Michigan, reported on the electronic information storage and retrieval revolution that has begun. The capacity exists to put all medical literature into computers and for retrieval at distant points. Pilot programs are in operation. Techniques to permit the reader to "browse" through the computers are being devised. The panel was urged to remember that computer output would only be as good as its input. Since mere automation will not prevent the physician from being overwhelmed by the sheer volume of new knowledge, the ultimate sophistication of information transmission services will be some kind of filter to insure that only what the physician needs will reach him. Of course, any such selection process will require discriminating professional judgment.

Mechanisms that presently speed information dissemination, as well as provide a functional filter, include the highly successful "Medical Letter on Drugs and Therapeutics." This 4-page paper edited by pharmacologists and internists attempts to review impartially new and old drugs, as a service to the local practitioner. This kind of publication might have far wider application. In addition, radio and and television programs and refresher courses are playing a role, and possibly through such media the lags in professional communication could be reduced.

Dr. John Knowles, Massachusetts General Hospital, Boston, observed that generalists, as members of the hospital's board of trustees, should actually direct hospitals and medical centers because they alone have the breadth of vision to insure that professional expertise is articulated with community needs.

Delivery of Health Care

The panel session on the delivery of health care, under the direction of Dr. Roger O. Egeberg, dean, University of Southern California School of Medicine, seemed to accept the proposition that whatever the method of delivery, either by group or solo fee-for-service practice, the personal, family-oriented physician remains the central figure. Furthermore, the essential elements of good quality health care, and how delivery influences it, are still largely matters of conjecture. There is precious little hard evidence to assist in selecting one system of delivery over another. Much more than the present level of less than 0.5 percent of the total medical research budget ought to be spent to evaluate different kinds of delivery systems.

Group practice, prepayment or otherwise, was a type of delivery system that received considerable attention. Prepayment plans have grown modestly since their inception 30 years ago. Yet this type of practice has been adopted by only 9 percent of America's physicians, and almost all of these groups are in the West. If this kind of practice is worthy of support, and there was substantial support in the group for this view, it must be recognized that Federal financial support would be required to encourage its development.

The medical center was criticized for failing to shoulder sufficient responsibility for community medical care. Dr. Count Gibson, Tufts University School of Medicine, suggested that the assumption of responsibility for the total care of a particular population group might be

a means to pry both faculty and students loose from the ivy tower and move them into the community. Such an enterprise would be an invaluable resource for information on how to deliver medical care, as well as a means to teach students that medicine exists beyond the confines of the hospital.

It was pointed out that cultural patterns greatly influence the delivery of health care and every effort should be made to involve the patients, including the poor, in the operations of delivery systems for them. Mrs. Ione Carey, Visiting Nurse Service of New York, described a program in which home aides served as the link between the professional and the patient.

Economics of Health Care

The economics of health care was discussed with considerable heat in the panel moderated by Jerome Pollack, Harvard Medical School. Health was recognized as big business, costing about $40 billion annually, or almost 6 percent of the gross national product. Almost 3 million Americans are engaged in health work. Most viewed rising costs for health care as inevitable. We should direct our efforts toward controlling and meeting those costs, while simultaneously encouraging the best quality of medical care.

Financing affects utilization and quality. It was felt by some that the traditional fee-for-service, limited-benefit insurance schemes have probably discouraged the development of truly comprehensive health care programs that include promotion and restoration of health, as well as reparative care.

It was noted that in a health care economy of scarcity, the rich and poor must compete for services. We must equalize the services, while elevating them for all. The place of governmental assistance, through tax credits or a negative income tax, was considered. Better coordination of public funding and private insurance was predicted as the path of the future. The success of our system of health care will depend on the inventiveness with which we develop the public and private partnership.

Planning for better construction of facilities and better provision and deployment of manpower was universally felt to be not only desirable but essential. Regional planning units, with growing statutory power to regulate, were described as a welcome new phenomenon. The heart, cancer, and stroke programs may set the pattern for better national dispersal of the high quality health care available in the university medical center to the peripheral community. For the first time, the Federal Government is putting funds into the mainstream of health care, instead of into categorical "poor law programs."

Quality of Health Care

Dr. Dwight L. Wilbur, Stanford University School of Medicine, moderated the panel on the quality of health care. Although medical care in America was usually felt to be of very high quality, there was no evidence of smugness in the group. The physician should encourage improvement by applying peer judgment either through group practice or hospital associations. But it also recognized that high quality care was a joint responsibility involving the public, the government, and the profession.

The medical audit has proved to be feasible even where applied to office practice. Dr. Ray E. Trussell, Columbia University School of Public Health and Administrative Medicine, described how New York City, by using its licensing power, had imposed certain specific standards of medical practice in all hospitals. The wisdom of using city authority to encourage hospitals to affiliate with medical centers was demonstrated by the results of a medical audit which revealed that medical practice was best at the university-affiliated hospitals.

Nathan Stark, vice president of Hallmark Cards, Incorporated, pointed out that although the patient has a great interest in quality, he is not easily able to influence it. Acting alone, the patient does not always have the knowledge to determine what quality should be, but the judgment and effectiveness of groups of patients acting in concert was felt to be considerable. Some questioned whether a system which requires the patient to select his own physician serves the best interest of the patient.

Community Health Care Planning

The panel on community health care planning moderated by Ray Brown, Duke University Medical Center, accepted without dissent the premise that planning was necessary. Ran-

dom development of health services could not possibly meet the complex demands of the 20th century. Moreover, as Brown pointed out, planning itself was not enough, but the plan must be implemented. As Philip Rutledge, Mayor's Committee, Total Action Against Poverty, Detroit, Mich., observed, the planning of health care was too important to be left solely to physicians. Any meaningful scheme would have to be tempered by the social and economic considerations of the community.

Thus, the discussion centered on strategy rather than goals. It was found that the term "community" has different meanings for different people—a union, a city, a State, or a population region. There was no obvious answer to the question, "Who should plan?" The community has to be defined, and a forum provided to permit providers of health services, as well as those who use the services, a chance to mutually develop plans. State health departments, voluntary agencies, medical centers, and private physicians have too often in the past worked at cross-purposes.

Individual aims have to be subordinated to larger community needs. In the future, decisions about health and health care are going to be public business. This demands an involved and informed public.

Special Health Care Needs

Dr. George James, president, National Health Council, managed to confine the somewhat diffused panel on special health care needs to a few special areas. His opening paper reflected general concern with how to bring health services to all the people. That the poor do not receive proper medical care was dramatized by figures correlating per capita income with life expectancy and infant mortality. Fragmented services offered at times and places inconvenient for the people are all too common. But he has shown in New York City that government and voluntary institutions can cooperate to build services to suit the needs of patients, and not vice versa.

The needs of the victim of racial discrimination, often doubly damned by poverty, came in for particular attention. Dr. Leonidas Berry, of Michael Reese and Provident Hospitals, Chicago, felt that the Negro wants not "special" health care, but rather standard care specially directed to him. As a matter of fact, there was some feeling that "special" treatment had caused some of today's problems. It was agreed, however, that special attempts, in terms of the attractiveness and availability of service that James mentioned, would be required to bring high quality care to the ghetto dweller.

Children, the elderly, and the disabled were identified as groups who require more than the acute episodic attention sought by the working adult population. The possible rewards, in terms of increasing human potential, are surely worth the effort. A new kind of professional attitude is needed if health workers, social and behavioral scientists, economists, city planners, voluntary agencies, and government are to cooperate in providing these services.

Health Protection

The six panels devoted to an examination of health protection met following a general session addressed by Senator Lister Hill of Alabama and Congressman John Fogarty of Rhode Island. Congressman Fogarty urged the delegates to keep in mind, "The relationship of a smoggy, noisy, crowded city environment to mental health, . . . of mental health to recreation, . . . of recreation areas to the planning of churning cities of the future, . . . of those cities and their development to the need for family planning for the future, and the relationship of each to all of the others."

Consumer Protection

Participants in the panel on consumer protection tried to identify the roles of government, the medical profession, and the public in this area. Moderator Colston Warne, president, Consumers Union of the United States, made it clear that in spite of great strides in controlling communicable disease, eliminating toxins, and eradicating food poisons, more had to be done. Furthermore, we must always be alert to the new dangers that manmade modifications of the environment create.

Cigarette smoking was one problem agreed to be of special magnitude. If evidence were needed, the estimated 300,000 premature deaths that smoking causes each year, to say nothing of the thousands more made respiratory or cardiac

cripples, would surely suffice, yet cigarette consumption has so far failed to decline. The impotence of our efforts to date may, in part, merely reflect the fact that medicine cannot now help smokers to stop. In addition the participants were urged to remember that any successful campaign against the sotweed factor would have to take cognizance of the broader social issues involved—for example, the vast national economic involvement in the tobacco industry.

Accident Prevention

Accident prevention, a seemingly timeworn theme, was found in the panel session chaired by Dr. Ross McFarland, Harvard School of Public Health, to be a topic about which woefully little is known. Industry has found that identification of hazards and the establishment and enforcement of rules dramatically curtails accidents. In the home, where the majority of accidents occur, similar steps are not applicable.

Highway mayhem, still a major cause of death and dismemberment, was noted to be related to the use of alcohol more than 50 percent of the time. The implications are clear.

It was also brought out that the automobile industry is not yet applying all its knowledge to produce the safest cars it can. There was widespread agreement that government surveillance will be required to stimulate industry to greater efforts.

Participants pondered the relative roles of environment and behavior in accidents. It was generally felt that there are limits to the flexibility of the environment, but that continuing public education, seriously conducted, can modify human action and reduce accidents. The health professional can and should play an active role in such an educational program.

Environmental Health

A new "human right to beauty" was the suggestion of architect Philip Will of Chicago to the panel session on environmental health. Man is a captive of his environment, but he can create freedom and beauty within it, if only he has the will. Today the technology is available, the climate of opinion is receptive, and the desecration of our environment is so visible, that corrective action is feasible. The price for beauty is high, but the rewards are infinite. To change an environment whose design has too often been governed by expediency, private license, and dollar morality, committed active public involvement will be required.

Crisis response to water and air pollution, so characteristic of our past, should not be the pattern of the future. We need regional watershed programs to insure an adequate supply of potable water. Federal support will be required to realize this goal. The watersheds should be planned so that pleasure, as well as sustenance, can be drawn from them.

Air, less definable than water, requires even more vigorous control. The air envelope has no national boundaries, much less State or city boundaries. Our approach to control must thus be global. The exhaust of cars, industries, and homes makes research to identify, prevent, and correct pollution imperative. The involvement of conflicting economic and political interests makes mandatory a vigorous authority to enforce the rules.

Mental Health

The panel session on mental health proved to be an opportunity to survey the broad scope of medical practice. There was widespread agreement that programs designed to promote mental health have to be part of the larger fabric of community planning and that these must be tailored to local needs.

Psychiatrists can no longer be content with the psychodynamic treatment of the single acutely ill patient but must intervene in the social situation to promote mental health. An example of such total environmental intervention has been provided by the Peace Corps. The few psychiatrists in the program tried to define problems the group would face and then strengthen individuals to meet those stresses. This broader concept of active, aggressive mental health promotion not only yielded a remarkably sound group of Peace Corps volunteers, but it also enabled them to offer mental health education to the people they served. Thus, the potential of a few professionals was multiplied many times over. In these returning Peace Corps volunteers, the community now possesses a resource of considerable value in any mental health action program. They should be used.

Attention was focused on the particular problems of the poor and deprived who have not only considerably more emotional dislocation, but less access to assistance. And of possibly greater importance, the patient and health worker are too often unable to communicate. More effort must be made to bridge the cultural gap that separates them. Quite possibly a nonprofessional aide could serve such a function.

Family Planning

The panel on family planning represented the first specific attention given this topic in a national forum. Since the focus was on the United States, discussion centered on the quality of individual life rather than on the aggregate population explosion. As Dr. George Shuster, University of Notre Dame, said, "uncontrolled procreation can well be an ax, which cuts to the heart of responsible parenthood."

Dr. Theodore H. Schultz, University of Chicago, the panel moderator, established two specific guidelines which dominated subsequent discussion. First, no effort could or should be made to violate conscience or coerce individuals. Second, each family should have the right and the ability to determine its size.

In the view of many participants, everyone should be aware of the available knowledge and have access to devices to control conception. Dr. Alan Guttmacher, president, Planned Parenthood-World Population, pointed out that 4.5 million American women are not getting adequate contraceptive advice. The poor, living in the most oppressive conditions, usually have the least access to and the most need for birth control information. Their high birth rate, with its attendant ugliness of illegal abortion, contributes to the disintegration of the family and the perpetuation of the culture of poverty. Guttmacher called for a Federal expenditure of $65 to $95 million to reach these disadvantaged women.

It was suggested that family planning should be available in every hospital, that it should be a routine part of the care of every obstetrical case, and that social workers should be trained to bring appropriate information to their clients.

Several speakers urged the audience to remember that birth control programs do not exist in a vacuum. Appropriate psychological and social guidance should accompany all contraceptive advice. We must also intensify our efforts to understand and treat human infertility.

Health Promotion

The panel on health promotion was the site of a discussion of man, his genes, and his environment, under the chairmanship of Dr. Lenor Goerke, University of California School of Public Health, Los Angeles.

Among the topics considered was physical fitness, and Dr. Charles Houston of the Peace Corps noted that our emphasis on games has not resulted in this nation developing a popular commitment to exercise. He suggested that young people be exposed by their parents, in a regular fashion, to exercise. The community should encourage this by providing adequate, safe, pleasant sites for hiking, camping, and similar pursuits. Playgrounds should be far more widely available and for longer hours. One speaker pointed to the popular European resorts to promote health where a balanced program of exercise and leisure is available to rehabilitate and renew before degenerative illness has taken over.

Health education, a subject frequently mentioned at the conference, occupied a large part of this panel. Peter Wyden of the *Ladies Home Journal* pointed out efforts of his magazine and other mass media to educate the public about good health habits. While not denying the value of such efforts, Dr. Paul Cornely, Howard University College of Medicine, pointed out that such communications, aimed at the middle class, fails to reach other Americans desperately in need of this instruction. A more determined and sophisticated effort would have to be made to reach the poor, the retired, and the disadvantaged, he said.

Nutrition in an affluent society proved to be an area where unmet needs continue to exist while the ability to deal with them is already present. Tooth decay can be curtailed by fluoridation, yet most of our people do without this simple, inexpensive health promoter. Poor eating habits lead to obesity and predispose to cardiovascular disease. Obesity now affects an estimated 79 million Americans of all social and

racial groups. Wyden felt that the government should provide diet information that is positive and readable and devoid of dry, obscure technical language.

Speakers on the final day were Secretary of State Dean Rusk and Director-General Marcolino Candau of the World Health Organization. Secretary Rusk pledged that cold war strategy would never impede free commerce of medical knowledge. He called the export of American health capacity one of the strongest aspects of our foreign policy. Candau reminded the audience that communicable diseases are still everyday scourges for most of the world. Money spent by the developed countries in maintaining their isolation from the diseases might be more profitably spent in a massive effort to eliminate them. He urged that the United States support the development of educational facilities to train local health personnel.

At the final summary session conference vice-chairmen Lowell T. Coggeshall, vice president, University of Chicago, Marion B. Folsom, former Secretary of Health, Education, and Welfare, and Dr. Leona Baumgartner, former commissioner of health, New York City, attempted to identify the themes of the 18 panel sessions and 36 hours of discussion of the preceding 2 days.

Nothing was more clear than that a new era in American medicine is possible. The knowledge and the resources are available. The medical profession, the universities, the government, and private individuals, working in concert, can rationalize our health establishment to meet the growing demands of a changing society. We may still be operating in a health economy of scarcity, but this conference was unwilling to accept that as inevitable. The sense of the conference was that the tremendous expansion and reorganization of resources required to make good the promise of health as a human right awaited only our commitment and action.

Mr. Stevenson Named Chief Engineer

Albert Henry Stevenson has been appointed Assistant Surgeon General and Chief Engineer of the Public Health Service, succeeding Callis H. Atkins, who retired January 16, 1966.

Mr. Stevenson, formerly chief of the Office of Environmental Health, Division of Indian Health, has been an engineer officer with the Public Health Service since 1942. Born in Brooklyn, N.Y., in 1914, he was graduated in civil engineering at Union College, Schenectady, N.Y., and took his master's degree at Harvard University. He worked for the New York State Health Department in its Syracuse District and for the consulting engineering firm of Malcolm Pirnie prior to being commissioned in the Public Health Service.

He was assigned to the Health, Education, and Welfare Regional Office in New York City from 1942 to 1947, when he was transferred to Cincinnati, Ohio, as sanitary engineer and executive officer of what is now the Robert A. Taft Sanitary Engineering Center. He became deputy officer in charge of the Center in 1951 and retained that post until 1954, when he was detailed to the Federal Civil Defense Administration as its chief sanitary engineer. He has been chief sanitary engineer of the Division of Indian Health since 1956.

Mr. Stevenson is a member of the American Society of Civil Engineers, the American Water Works Association, the American Public Health Association, Harvard Engineering Society, and the Conference of State Sanitary Engineers. He received the Public Health Service Meritorious Service Medal in 1963.