find that Title I of the bill does not propose to broaden the construction authority for Regional Medical Programs. During the initial hearings before the Interstate and Foreign Commerce Committee on Regional Medical Programs in 1965, there was much testimony that construction authority would be necessary if the requirements of the legislation were fully to be met. The committee in modifying the bill deleted the authority for new construction. In its report on the bill the committee reasoned that the program would not be jeopardized by the lack of such authority in its initial planning phases. Furthermore, the committee felt in those instances in which new construction might be required for Regional Medical Programs, other Federal sources of funding should be sought. Finally the committee in its report indicated its intention to review this question at the time of the legislation's extension.

Mr. Chairman, I would like to commend the committee's wisdom on this matter. In fact, the Regional Medical Programs have not been jeopardized during these past three years, during which they have organized themselves, planned their programs and begun to enter the operational phase.

However, this situation is rapidly changing. Already 12 of the 54 Regional Programs are operational and within the next year or so all of them will have begun operations. Accordingly, their needs for additional facilities will rapidly increase.

The Surgeon General's Report to the President and The Congress on Regional Medical Programs documents the case for limited Regional Medical Program construction authority. It is extremely important to understand that these facilities would principally be located in community hospitals, not our medical schools.

Examples of needed community hospital construction described in the report include class and conference rooms for regional continuing education programs, space for special demonstrations of community patient care, and expanded diagnostic laboratory facilities.

These needs are not now being met under existing Federal construction programs. There are two interrelated reasons for this:

(1) The competition for Federal funds for the construction of health facilities has grown enormously as a result of an overwhelming demand for such facilities.

(2) By definition, the nature of Regional Medical Program construction needs goes beyond the needs of a single institution to the needs of the region. Accordingly, it is unreasonable to assume that any *single* institution would be willing to divert its scarce funds for matching purposes when the benefits of the facility are intended for *many* institutions.

Since it is essential that there be no substantial distortion of the concept of Regional Medical Programs, I concur that rather strict limitations should be placed on this vitally needed construction authority. The kinds of limitations one finds in the Surgeon General's report, having to do with the amount of funds available for construction purposes, seem entirely reasonable to me.

Having considered the limitations, what kind of Regional Program projects are we working to generate? How does such a project work? An example of the effective implementation of the program involving community hospitals is provided by the Rochester (New York) Regional Medical Program which has inaugurated an initial five-part operational program in the area of cardiovascular disease. Each part is specifically designed to meet observed or expressed needs in the delivery of specialized medical care to the heart patient. One project will provide postgraduate training in cardiology for general practitioners and internists who practice medicine in the ten counties which make up this region. Several different training programs will be offered so as to best meet the individual needs of the physicians who will participate. This program is being persented in direct response to the requests of physicians for this type of assistance. One phase of this program includes visitations to peripheral hospitals by the cardiologists who will provide this instruction. Certain audio-visual equipment will be placed in these peripheral hospitals for continued use by the local physician.

A parallel program will present intensive month long courses to prepare professional nurses in the management of coronary care units. The growth in the number of coronary care units which provide essential medical care during the acute phases of cardiac illness, has created an urgent need for an increased number of well trained nurses; the latest advances in nursing techniques and modern life-saving equipment demands specialized instruction in the nursing skills re-