mittee meeting that most of us had the same feeling. Then it was interesting to see the change in everyone as the meeting progressed. It seemed that most of us had very definite, but very erroneous ideas of what the regional medical program would be and how it would work. It was explained in the first session in May of 1966 that the regional medical program was not going to be a vehicle to transport the patient to "supercenters" but rather was going to be a vehicle to transport knowledge, technique, and assistance to the local level to improve patient care in places such as Omak. I, of course, was very suspicious that this was just the bait to lure us into the trap. I have now completed approximately 20 months on this committee, and I am convinced that at least the Washington-Alaska program has not altered from this ideal; that is, to attempt to improve the level of care for victims of heart disease, cancer, and stroke and related diseases into local communities. I was also prejudiced in another area as I approached the work on the regional medical program. I am in a very rural community. I think it is wonderful to have great research projects and a large amount of what we call ivory tower medicine. But I also feel there is a tremendous amount of medicine that has to be practiced on a day-to-day basis to help the people receive proper care.

I also had many preconceived ideas about physician education programs that I felt were fairly worthless. I have taken these prejudices and conveyed them into ideas for our group, and am afraid I have helped to sidetrack certain programs I felt had little practical value.

I do want to say that I feel there is a definite place for complicated research projects, and without them many of the advances we enjoy today would not be here. But I feel, as the only general practitioner on the Advisory Committee, that I have wasted very little time arguing for the aspect of medicine because many about me are. In regard to specific problems that were present in the practice of medicine in north-central Washington these are some.

There are certainly many other problems which deal with rural areas, and many of these would fall in the categorical areas of the heart, cancer, and stroke program. We are looking forward to taking advantage of the coronary care unit training programs that are currently being established by our RMP and are looking forward to many other benefits from it. I think the point that I would like to make so strongly is that the RMP has offered the first opportunity for local medical communities to feel that it is worthwhile to get involved and interested in because their opinions and problems are being sought.

There certainly has been a considerable change in stance of the average physician in regard to Government in medicine. Just a few years ago no cooperation would be offered, and if preferable no interference would be tolerated. Today we find the average physician understanding that the Government will be involved in medicine and that a cooperative venture of some kind would be most desirable. The RMP with its emphasis on regionalization has, I believe, caught the fancy of the medical communities of the United States. As I travel to various meetings with colleagues who are scattered across the country, I find that quite often they have many favorable comments concerning the aims and goals of this program. I think that if this pro-