

# MAINE STATE LEGISLATURE

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EIGHTY - SEVENTH LEGISLATURE

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Legislative Document

No. 36

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H. P. 96

House of Representatives, January 15, 1935.

Received and placed on file and 500 copies ordered printed of communication and accompanying papers. Sent up for concurrence.

HARVEY R. PEASE, Clerk.

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STATE OF MAINE

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IN THE YEAR OF OUR LORD NINETEEN HUNDRED  
THIRTY-FIVE

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STATE OF MAINE  
DEPARTMENT OF STATE  
Augusta

January 10, 1935.

To the Clerk of the House of Representatives:

I have the honor to herewith transmit the report of the Commission on Medical Education, created by chapter twelve of the private and special laws of 1933.

LEWIS O. BARROWS,  
Secretary of State.

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To the Honorable Governor and Council:

The Commission on Medical Education created by an act of the 86th Legislature submits the following report:

To carry out the provisions of this act the work of the commission has been divided into four phases—first, to determine the number and distribution of physicians in Maine; second, to determine the advisability of establishing a medical school; third, to consider other suggestions for the promotion of medical education; and, fourth, to make specific recommendations for the most practical method of promoting medical education in the state.

## PART I

The commission finds that Maine compares favorably with other states in the number of physicians per thousand population. Table I gives figures taken from 1932-33 "Maine Register" showing that there is one physician to every nine hundred and four persons. A recent study by a commission on medical education organized by the Association of American Medical Colleges states "The experiences in certain industrial groups and communities indicate that a reasonably complete medical care can be provided on the basis of one physician to about twelve hundred persons, if the population group is large enough to permit effective use of specialized personnel necessary for complete service. In small isolated communities the ratio of physicians would need to be higher."

TABLE I

Counties	Population	Physicians
Androscoggin .....	71,214	74
Aroostook .....	86,504	63
Cumberland .....	134,645	205
Franklin .....	19,558	19
Hancock .....	30,592	35
Kennebec .....	70,691	89
Knox .....	27,672	35
Lincoln .....	15,498	17
Oxford .....	41,384	44
Penobscot .....	90,734	102
Piscataquis .....	17,613	18
Sagadahoc .....	16,902	15
Somerset .....	37,645	33
Waldo .....	20,286	25
Washington .....	36,310	36
York .....	72,934	71
Total .....	790,182	881

Note: Above information taken from "Maine Register" 1932-33.

The problem in Maine does not appear to be a scarcity of physicians but rather an uneven distribution. Table 2 shows the distribution of physicians by counties from 1870 to 1933. As seen by this table, the ratio of physicians to population is smallest in the rural sections of the state where, medical authorities say, it should be greatest. Aroostook, Franklin, Sagadahoc, Somerset, Washington and York are the counties which appear to be the most seriously affected by this situation. The table further shows that since 1910 there has been a continued decrease of physicians per thousand population, particularly in the more rural counties.

TABLE 2

Ratio of Number of Professional Physicians\* to Population of the State of  
Maine in Terms of Units per Thousand of Population by Counties

	1870	1880	1890	1900	1910	1920	1925	1928	1933
Androscoggin ...	1.286	1.444	1.354	1.777	1.627	1.292	1.086	1.381	1.067
Aroostook .....	.655	.634	.877	.988	1.189	.888	.696	.691	.705
Cumberland .....	1.317	1.662	1.6	1.799	1.001	1.871	1.633	1.622	1.516
Franklin .....	1.5	1.722	1.647	1.944	1.579	1.473	1.044	.035	.972
Hancock .....	.805	1.093	1.459	1.621	1.577	1.386	1.275	1.275	1.144
Kennebec .....	1.169	1.377	1.473	1.474	1.612	1.492	1.323	1.272	1.244
Knox .....	1.033	1.25	1.419	1.566	1.678	1.461	1.372	1.394	1.257
Lincoln .....	.8	.833	1.095	1.473	1.222	1.533	1.266	1.357	1.096
Oxford .....	1.484	1.562	1.866	1.937	1.666	1.513	1.205	1.102	1.039
Penobscot .....	1.026	1.271	1.458	1.815	1.752	1.482	1.442	1.253	1.124
Piscataquis ....	.714	1.5	1.312	1.625	1.631	1.268	.985	.809	.977
Sagadahoc .....	1.055	1.105	1.315	1.428	1.444	.999	.695	.608	.769
Somerset .....	1.294	1.437	1.718	1.728	1.777	1.351	1.081	.973	.876
Waldo .....	.971	1.25	1.777	1.708	1.782	1.381	1.231	1.473	1.232
Washington .....	.581	.841	1.136	1.555	1.866	1.195	1.127	.981	.991
York .....	1.166	1.322	1.596	1.483	1.736	1.431	1.211	1.055	.959
State Ratios ....	1.067	1.263	1.428	1.603	1.632	1.401	1.226	1.191	1.060

\*Omitting Osteopaths, Chiropractors, Christian Science Practitioners, etc.

Note: Data taken from "Maine Higher Education Survey."

The reason for this condition is obvious. In a questionnaire sent out to all physicians in the state listed in "Maine Register" for 1932-33 the principal reason given for a scarcity of physicians in the rural sections is economic conditions. Young doctors hesitate to enter into practice in a community where they are not assured of a good living. City practice offers more comfortable living conditions, easier hours and better financial returns. Then, too, it appears from the physicians' replies that many young doctors are graduating as specialists and are, therefore, better fitted for practice in the larger communities where hospital facilities are available. The day of the general practitioner appears to be waning.

On the other hand, the rural situation is not as serious as it would at first appear. Better roads and automobile travel have, of course, widened the territory which the country doctor can effectively serve. From the replies of physicians practicing in towns of 2500 population and less the average radius served by the rural practitioner in Maine is thirteen miles. With modern means of travel it is probable that a doctor can serve this area efficiently if the population of his district is approximately one thousand. There are districts in Maine, however, where physicians have a radius of from twenty-five to thirty-five miles to serve.

Another angle of this situation is that the average age of the physicians practicing in the smaller communities of the state is just under sixty. In a few more years, when these loyal medical men have been relieved from their duties, the communities they are now serving are likely to suffer if the trend of the younger physicians to locate in the city continues.

## PART 2

Ever since Bowdoin Medical School closed its doors in 1920 there has been considerable agitation in the state to establish a state medical school. In 1921 a bill was introduced into the 80th Legislature proposing to establish a state school for medicine. The bill was passed by both the House and the Senate but it was vetoed by Governor Baxter, who gave the following five fundamental reasons for his action:

“First: That the object for which the school would be established, the education of physicians who would be willing to practice their profession in the rural communities of the state, will not be attained if this resolve becomes a law;

“Second: That the state should not commit itself to the founding of the institution because our citizens do not thoroughly understand the questions at issue, and do not realize what financial and other problems, of the present and future, are involved by this proposed action;

“Third: That the state should not embark upon an enterprise of the magnitude unless it is prepared to maintain a medical school of the highest grade, and this would call for an expense far in excess of any appropriation provided for by this resolve;

“Fourth: That the present condition of the state’s finances and the heavy tax burdens now borne by our people do not justify the expenditure of the money required to found a new state institution, especially in view of the fact that the requirements of a state medical school would increase with each passing year;

“Fifth: That a state should not establish a state medicine any more than a state religion, and notwithstanding the language of the bill, that the school is for ‘all branches of medicine,’ it is understood that the course of study would be such as is usually provided for by one particular school of medicine. The individual should be free to select his own method of treatment and the taxpayers’ money should not be used for the advancement of any one medical or religious faith.”

Conditions today have not changed materially since 1921, except that roads are kept open better during the winter, and automobile travel has improved considerably, allowing better service in rural sections.

Establishing a Class A medical school involves the expenditure of a large sum of money and situation in a city with a large number of hospital beds for clinical facilities.

According to the recommendations of the American Medical Association the essentials of an approved medical school are given as follows :

#### **I. ORGANIZATION**

A medical school should be incorporated as a non-profit institution. Its board of trustees should be composed of public spirited men and women having no financial interest in the operations of the school or its associated hospitals. The trustees should serve for fairly long and overlapping terms. If the choice of trustees is vested in any other body than the board itself, that fact should be clearly stated. Officers and faculty of the school should be appointed by the board.

#### **II. FACULTY**

The school should have a competent teaching staff, graded and organized by departments. Appointments should be based on thorough training, successful teaching experience, ability in research, and willingness to pursue an academic career. In the clinical departments this does not exclude men who are in the active practice of medicine and surgery. Nominations for faculty positions should originate in the faculty, usually being made by the dean in consultation with the department heads or a committee of the faculty. Reasonable security of tenure must be assured in order that the personnel of the faculty may have adequate stability. In the preclinical sciences the faculty should include at least ten qualified persons of professorial rank (professorial rank as here used includes professors, associate professors and assistant professors) devoting their entire time to teaching and to that research without which they cannot well keep up with the rapid progress of medical science. For each twenty-five students in a class there should be at least one full-time assistant in each of the preclinical departments. Salaries should be sufficient to enable members of the faculty to support themselves and their families without the necessity of devoting time and energy to other occupations.

#### **III. PLANT**

The school should own, or enjoy the assured use of, modern fireproof buildings sufficient in size to provide lecture rooms, class laboratories, small laboratories for the members of the teaching staff and advanced students, administrative offices and a medical library. Equipment should be ade-

quate, both for student use and for research. A trained librarian should be employed to supervise the operation and development of the library, which should include the more modern text and reference books with the Quarterly Cumulative Index Medicus, the Index Catalogue of the Library of the Surgeon- General's Office and serviceable card indexes. The library should receive regularly all of the leading medical periodicals, the current numbers of which should be in racks or on tables easily accessible to the students. At the end of each year these periodicals should be bound and added to the files of bound periodicals.

There should be a medical museum having its various anatomic, embryologic, pathologic and other specimens carefully prepared, labeled and indexed so that they may be easily found and employed for teaching purposes. With each pathologic specimen coming from postmortems there should also be kept the record of the postmortem, the clinical history of the patient on whom the necropsy was held, and microscopic slides showing the minute structure of the disease shown in the gross specimen. The museum furnishes an excellent means of correlating the work of the department of pathology with that of the clinical departments.

There should be sufficient dissecting material to enable each student to dissect at least the lateral half of the human cadaver, to provide cross-sections and other demonstration material and to allow a thorough course for each senior in operative surgery on the cadaver.

For experimental laboratory work, as well as for medical research, a supply of animals is essential. Proper provision is necessary also for the housing and care of such animals. In any use made of animals every precaution should be taken to prevent suffering, and work by students should be carefully supervised.

Each school should have such useful auxiliary apparatus as stereopticons, reflectoscopes, microprojectors, carefully prepared charts, embryologic or other models, manikins, dummies for use in bandaging, roentgen-ray apparatus, and other aids to effective teaching.

#### IV. CLINICAL FACILITIES

The school may own or control a general hospital. By control is meant the unquestioned right to appoint the attending staff. In this event the students come into close and extended contact with patients under adequate supervision. In the event that a medical school depends for clinical teaching on an independent hospital, it is essential that the clinical teachers, either on nomination by the school or by agreement in conference between school and hospital, be appointed by the hospital trustees to appropriate positions on the hospital staff. Such hospitals should be in close

proximity to the school and have a daily average of not less than 200 patients who can be utilized for clinical teaching, these patients to be of such character as to permit the students to see and study the common variety of surgical and medical cases as well as a fair number in each of the so-called specialties. In the use of this material, bedside and ward clinics should be developed for sections of from five to ten students; and patients in medicine, surgery and the specialties should be assigned to each student under a well supervised clinical clerk system. The treatment and care of these patients should be particularly observed and recorded by the student under the strict supervision of the intern, the resident or the attending staff of the hospital. The use of existing municipal or state hospitals for teaching purposes is also advised.

The school should also own or control ample hospital facilities for children's diseases, contagious diseases and nervous and mental diseases.

The school should own or control a well ordered dispensary or outpatient department with a daily average attendance of at least 100 patients (visits). Good histories and records of the patients should be kept and the material used in medical instruction. The attending staff should be drawn largely from the faculty, including those of highest rank.

At least fifteen maternity cases should be provided for each senior student, who should have actual charge of these cases under the supervision of the clinical instructor. A carefully prepared report of each case should be handed in by the student.

Facilities should be provided for at least fifty necropsies during each school session which are attended and participated in by students. These should be performed by the professor of pathology or a member of his staff. The material thus secured should be used in connection with clinical pathologic conferences.

## V. RESOURCES

Experience has shown that modern medicine cannot be acceptably taught by a school which depends solely on the income from students' fees. No medical school, therefore, can expect to secure approval which does not have a substantial income in addition to students' fees. This statement carries double weight if the school finds it necessary to maintain its own teaching hospital.

## VI. ADMINISTRATION

There should be careful and intelligent supervision of the entire school by the dean or other executive officer who, by training and experience, is



fitted to interpret the prevailing standards in medical education, and who is clothed with sufficient authority to carry them into effect.

There should be a good system of records showing conveniently and in detail the credentials, attendance, grades and accounts of the students, by means of which an exact knowledge can be obtained regarding each student's work. Records should also be kept showing readily the attendance of students at the teaching hospitals and dispensaries and the maternity and post-mortem cases attended. The school should require that students be in actual attendance within the first week of each annual session and thereafter. Except for good cause, such as for illness, no credit should be given for any course when the attendance has been less than 80 per cent of the full time.

**Requirements for Admission.** The Council approves the statement regarding entrance requirements contained in the Constitution and By-Laws of the Association of American Medical Colleges, Section 4, page 11. (See Appendix).

A list of colleges of arts and sciences approved by the various national and regional standardizing agencies has been prepared by the United States Department of the Interior in a pamphlet entitled 'Accredited Higher Institutions.' Colleges on this list are acceptable to the Council on Medical Education and Hospitals. Other colleges of known reputability may also be considered when the students present extra credits and exceptionally high grades.

Premedical college courses given in or by professional schools, or advanced years taken in high schools, will not be considered acceptable unless the student's credentials have been accepted by an accredited college of arts and science as meeting a part of the requirement for the bachelor's degree.

The admission of students to the medical school must be in the hands of a responsible committee or examiner whose records shall always be open for inspection. Documentary evidence of the student's preliminary education should be obtained and kept on file. When the medical school is an integral part of the university, this work usually devolves on the university examiner. Unless the university examiner and his records are closely accessible, however, some officer at the medical school should obtain and keep on file documentary evidence of each student's preliminary education, including both high school and collegiate work. The records must show especially that the required amount of work in the premedical sciences, including laboratory experiments, has been completed.

The number of students to whom an adequate medical education can be given by a college is related approximately to the laboratory and hospital facilities available and to the size and qualifications of the teaching staff.

A close personal contact between students and members of the teaching staff results in an efficiency which is not possible in an institution where the number of students is excessive.

Advanced standing may be granted to students for work done in other acceptable medical schools, and in granting advanced standing there should be no discrimination against the school's full course students. Official verification of the student's previous medical work should be obtained by direct correspondence with the schools previously attended, and his preliminary qualification should also be verified and recorded the same as for freshmen students.

**Publications.** The school should issue, at least annually, a bulletin setting forth the character of the work which it offers. Such announcement should contain a list of the members of the faculty with their respective qualifications. The courses available should be set forth by departments (Anatomy, physiology, etc.) showing for each course its number, subject, content, character (lecture, recitation, laboratory or clinic), length of time, when, where and by whom given, and the amount of credit allowed. Information should be given regarding entrance requirements and tuition fees. The names of the students enrolled during the current or previous sessions should also be included.

## VII. CURRICULUM

The Council approves the statement regarding the curriculum as contained in the Constitution and By-Laws of the Association of American Medical Colleges, Section 5, page 13. (See Appendix).

Several of the medical schools now require an internship for graduation. Where it is not required it should be strongly urged and graduates should be assisted in securing internships in hospitals approved by the Council on Medical Education and Hospitals of the American Medical Association.

## APPENDIX

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**From the Constitution and By-Laws of the  
Association of American Medical Colleges  
(As amended Nov. 15, 1932)**

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**Sec. 4. Requirements for Admission.** Admission to medical schools and medical colleges in membership in the Association may be by:

- (1) Satisfactory completion of a minimum of collegiate instruction, as provided below in Subsection I; or by
- (2) Examination, as provided in Subsection II.

Subsection I.\* The minimum of collegiate credit required for entrance to medical schools and colleges in membership in the Association shall be not less than two full academic years, which shall include English, theoretical and practical courses in physics and biology, and in general and organic chemistry, completed in institutions approved by accrediting agencies acceptable to the Executive Council of the Association. Exception may be made under this section in that any member may admit applicants who have fulfilled the requirements in American and Canadian institutions not approved by such accrediting agencies, provided that all admissions so made be reported to the Executive Council and shall be published in the next Annual Report of the Council.

All collegiate instruction given in satisfaction of this requirement must be based on the same entrance requirements and must be of the same quality and standard of instruction as that required for a baccalaureate degree in the institution in which the candidate receives his preparation.

Subsection II. Admission to medical schools and medical colleges in the Association may be by examination.

Examinations for the purpose of admission by this method shall be conducted by institutions acceptable to the Executive Council of the Association, under the following conditions:

(a) Candidates who have completed two years of collegiate instruction and present evidence of general scholarship of high order, but who lack credits in not more than two of the required subjects, may be admitted on passing examinations in these subjects.

(b) Candidates who have completed three years of collegiate instruction and present evidence of having accomplished work of distinction in one or more fields of learning, but who lack credit in any or all of the required subjects, may be admitted on passing examinations in these subjects.

**Sec. 5. Curriculum.** The entire course of four years shall consist of from 3,600 to 4,400 hours, distributed as from 900 to 1,100 hours per year, and shall be grouped as set forth in the following schedule, each group to be allotted approximately the percentage of hours of the whole number of hours in the courses as stated.

1. Anatomy, including embryology and histology . . . . .	14	—	18½%
2. Physiology . . . . .	4½	—	6 %
3. Biochemistry . . . . .	3½	—	4½%

\*Inasmuch as many schools have admission requirements differing from those given in this section, it is important that intending students of medicine, at an early date, inform themselves as to the exact requirements of that school in which they expect to matriculate.

4. Pathology, bacteriology and immunology .....	10	—	13	%
5. Pharmacology .....	4	—	5	%
6. Hygiene and sanitation .....	3	—	4	%
7. General medicine .....	20	—	26½	%
Neurology and psychiatry				
Pediatrics				
Dermatology and syphilis				
8. General surgery .....	13	—	17½	%
Orthopedic surgery				
Urology				
Ophthalmology				
Otolaryngology				
Roentgenology				
9. Obstetrics and gynecology .....	4	—	5	%
Total .....	76		100	%
Electives .....	24	—	0	%

When the teaching conditions demand it, a subject may be transferred from one division to another.

Sec. 6. Any medical school or medical college in membership in the Association may, with the consent of the Executive Council, conduct a six year combined collegiate and medical curriculum, provided conditions equivalent to those laid down in Sections 4 and 5 are fulfilled. The medical school must submit to the Executive Council of the Association, the proposed six year curriculum, giving the sequence of studies and the content of each course offered or any subsequent changes that may be contemplated before they go into effect. (56) (57)."

The cost of establishing a school of medicine meeting the above recommendations of the American Medical Association would be enormous. It has been estimated by authorities who have made a more detailed study of the problem than is possible by this Commission that at least two million dollars would be required to inaugurate such a program. In addition to the cost of buildings and equipment, a large annual subsidy would be necessary since the tuition fees would never be sufficient to meet the operating costs.

The following States now maintain medical schools as part of the State universities:

Alabama, Arkansas, California, Colorado, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, and Wisconsin.

From inquiries sent to the above schools most nearly resembling what Maine might expect for a medical school, the Commission learns that the annual operating costs vary from \$105,000 to \$275,000. The most costly part of operating a medical school appears to be the expense incurred in providing clinical facilities. For example, the University of Kansas School

of Medicine is operating in two divisions, the first year and a half being at the University of Lawrence and the last two and a half years at Kansas City where there is a much larger amount of clinical material available. The budget for the departments at Lawrence, which include Anatomy, **Bacteriology**, Physiology, and Biochemistry, is approximately \$55,000; whereas, the budget for the Kansas City division, which includes the running of a 240 bed hospital, totals \$202,000.

A recent report of the Commission of Medical Education organized by the Association of American Medical Colleges has the following interesting data in connection with the cost of medical education:

"At the present time it is costing approximately \$13,000,000 per year for the maintenance of medical schools in the United States and Canada.

"The budgets of many schools have increased from two hundred to a thousand per cent during the past fifteen years, and the growth in endowments has been even larger. The largest single item of increase in the budgets in a number of instances is for salaries and other expenses in the clinical divisions.

"The sources of income of sixty-three schools are shown in the following table:

Students' fees .....	\$ 4,057,304
Endowment income .....	2,784,527
State or city .....	2,574,973
Other sources .....	<u>2,567,059</u>
	\$11,983,863

"The average cost of maintaining the medical schools was \$704 per year per student for 1926-27. The average student's fees paid was \$254. The difference between the average cost and the average fee paid by students represents about \$450 per year, which must be paid by income from endowments and other sources."

Possible sites for a medical school have been carefully considered by the commission. The location of a medical school depends largely upon the available clinical facilities. Bangor, Lewiston, and Portland offer the best possibilities, but even these cities lack the hospital facilities recommended by the American Medical Association.

Other states have found it advantageous to operate schools of medicine in conjunction with their state universities; and should Maine establish a medical school, Bangor, in close proximity to the University of Maine, would be desirable from that viewpoint. The Eastern Maine General Hospital, however, in the opinion of most physicians, at present does not offer adequate clinical facilities for an approved school of medicine.

Lewiston has much to recommend itself as a state center for medical education. It has been suggested that Bates College would be interested

in such a project. In Lewiston, however, as in Bangor, hospital facilities are not adequate to meet the needs of a class A medical school.

Portland most nearly meets the requirements of the American Medical Association for clinical facilities. The Maine General Hospital, although not large enough to provide the number of beds recommended by the American Medical Association, would be adequate for a school with a small enrollment.

The question arises, would a school of medicine established within the state in any way encourage physicians to locate in Maine? Data gathered by the "Maine Higher Education Survey" indicates that a large number of the graduates of the Bowdoin Medical School located in Maine. A large percentage of the physicians now practicing in the small communities of the state are graduates of the Bowdoin Medical School.

Table 3 shows that in 1930, ten years after the Bowdoin Medical School was abolished, 37.4% of all physicians practicing in Maine were educated professionally in the state.

Table 4 shows that in 1930 of the 444 physicians who were natives of Maine 52.1% were educated professionally in the state.

**TABLE 3**

Geographical Location of Institutions in Which Maine Physicians and Surgeons Prepared Regardless of their Nativity

	Per Cent	Number
MAINE .....	37.4	367
California .....	.4	4
Colorado .....	.1	1
Connecticut .....	.6	6
District of Columbia .....	.7	7
Georgia .....	.1	1
Illinois .....	1.2	12
Iowa .....	.2	2
Kentucky .....	.2	2
Maryland .....	7.6	75
Massachusetts .....	15.7	153
Michigan .....	.8	8
Missouri .....	.1	1
Nebraska .....	.2	2
New Hampshire .....	3.0	29
New York .....	6.8	67
Ohio .....	1.1	11
Pennsylvania .....	7.2	71
Tennessee .....	.2	2
Vermont .....	7.8	77
Wisconsin .....	.1	1
Canada .....	8.4	83
Scotland .....	.1	1
Totals .....	100	983

Note: Data taken from "Maine Higher Education Survey." Read table as follows: Of the 983 physicians and surgeons concerning whom adequate data could be gathered, 367 or 37.4% were educated professionally in the state of Maine.

TABLE 4

Geographical Location of Institutions in Which Maine Physicians and Surgeons of Maine Nativity Prepared

	Per Cent	Number
MAINE .....	52.1	231
Connecticut .....	1.1	5
District of Columbia .....	.2	1
Illinois .....	.7	3
Maryland .....	6.5	29
Massachusetts .....	15.1	67
Michigan .....	.2	1
New Hampshire .....	1.6	7
New York .....	6.3	28
Pennsylvania .....	6.5	29
Vermont .....	7.7	34
Canada .....	2.0	9
Totals .....	100.0	444

Note: Data taken from the records of the Maine Medical Association for 1930. Read table as follows: Of the 444 physicians and surgeons whose State of Maine nativity could be determined, 231 or 52.1 were educated professionally in the state of Maine.

The opinion of Maine physicians in regard to establishing a medical school is interesting. In a questionnaire sent to physicians listed in the 1932-33 Maine Register this question was asked: "In your opinion is there a need for a class A medical school in Maine?" In 497 replies 275 answered no, 194 yes, and 28 were doubtful.

While there is a feeling among the physicians of the state that something should be done to encourage young people who are desirous of securing a medical education, there is a decided sentiment in opposition to establishing any kind of institution other than a class A medical school, and a strong feeling that at the present time it would be impractical to attempt such a project.

### PART 3

The commission has considered a great many suggestions for promoting medical education in Maine by means other than a medical school.

The suggestion most often put forward is that the state encourage and assist young people who are desirous of studying medicine by granting scholarships conditioned on practicing three to five years in rural Maine.

This would not be a very expensive plan and would have two praiseworthy results: it would give to the young man or woman who has the

ability but lacks the financial means an opportunity to study medicine, and it would assist in a small way in solving the uneven distribution of physicians in the rural sections of the state.

### Suggestions Gleaned from Replies of Physicians to Questionnaire

State scholarships conditioned on practicing three to five years in rural Maine. Post-graduate teaching clinics in Lewiston, Bangor and Portland and affiliating scholarships in Boston medical schools for the three general hospitals.

A summer course for medical men now in practice.

Health centers in various parts of the state would provide medical services for all.

Standard medical journals placed in local public libraries would help men already in practice in Maine to keep abreast of the times.

Additional community hospitals.

Three year courses for students of limited means to prepare for general practice. Apprenticing students to best practitioners during summer months.

Laboratories and X-ray facilities, etc., made available to physicians now located in Maine would improve medical care.

## PART 4

The commission feels that it would be inadvisable to establish a medical school at this time.

The commission recognizes the need of medical service in certain rural sections of the state, but feels that the establishment of a medical school would but partially solve the problem.

The magnitude of the enterprise would call for an appropriation of money beyond the ability of the State to raise at this particular time.

Recognizing the need of medical service in certain rural sections of the State, the Commission recommends the passage of legislation that embodies the following:

1. That the State annually provide a limited number of medical scholarships for resident young men or women, enabling them to study medicine in any approved medical school, and granted upon the following conditions:

A. That upon completion of their formal medical education they return to the State to practice for a limited number of years in towns where, in the opinion of the State, medical service is needed; and

B. That during the first ten years of their practice they return to the State the money loaned for their medical education.

2. That a Commission on Medical Education be created to carry out the provisions of any legislation relating to such medical scholarships.

The following Act embodies the above recommendations:



STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED  
THIRTY-FIVE

**AN ACT Providing Medical Service for Small Towns.**

Be it enacted by the People of the State of Maine, as follows:

**Sec. 1. Commission on Medical Education created.** There is hereby created a commission for medical assistance for small towns, to be composed of 3 members, 1 physician, 1 educator, and 1 other citizen, all to be appointed by the governor, with the consent of the Council, to serve for a period of 3 years, 2 years and 1 year respectively. At the expiration of the term of office of any member, the same member or a new member in the same classification shall be appointed for a term of 3 years. In case of a vacancy because of death, resignation or otherwise a new member in the same classification shall be appointed for the unexpired portion of the term. The members shall receive their actual reasonable expenses incurred in the performance of their duties. A chairman and a secretary shall be elected by the commission from among its members.

**Sec. 2. "Medical education fund" created.** A "medical education fund" shall be set up for the purpose of establishing scholarships to assist worthy students in completing their medical education. There shall be appropriated by the legislature the sum of \$1000 for the fiscal year 1935-36; the sum of \$2000 for the fiscal year 1936-37; the sum of \$3000 for the fiscal year 1937-38; and \$4000 for the fiscal year 1938-39; and so much annually thereafter as may be necessary to have the amount of \$4000 annually available in the fund. In addition there shall annually be appropriated such a sum as will take care of the expenses of the commission.

**Sec. 3. Medical students to be assisted; conditions.** The commission shall select 2 candidates annually, by such method as seems best to them, who shall receive a loan of \$500 each annually for 4 years to assist them in obtaining a medical education at some competent university. The condition of the loan shall be that the student shall practice for the first 3 years after the completion of his preparation for practice in a town in Maine whose population does not exceed 1500. The commission shall act as the agents for the State in the arrangement of the details of the making of the loans and of the method of repayments. All repayments shall be credited to the "medical education fund."

SANGER M. COOK, Chairman

ROSELLE WOODBRIDGE HUDDILSTON, Secretary

ERNEST V. CALL

LEWIS O. BARROWS

JOHN A. McDONALD