

America  
Challenges  
Medicine

Michael M. Davis

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### THE SPEAKER

MICHAEL M. DAVIS, a social scientist who has devoted his career to the problems of medical care, was born in 1879 in New York City. He received the A.B. from Columbia University in 1900, and the Ph.D. in sociology at the same university in 1906.

His interest in the economics, quality and organization of medical care spans more than half a century. From 1910 to 1920 he served as Director of the Boston Dispensary; he was Director of Medical Services of the Julius Rosenwald Fund in Chicago from 1928 to 1936.

During the latter period, as Professorial Lecturer at the University of Chicago, he was instrumental in establishment of the first graduate program in hospital administration in the country, under the auspices of the Graduate School of Business of the University.

Outstanding in the field of medical economics, he has served as consultant to committees of the United States Congress and to other groups. He has published twelve books and more than 250 articles.

### THE SERIES

The Michael M. Davis Lecture Series has been established as a forum for free and open inquiry into the social and economic aspects of medical care. Distinguished leaders in medicine, the social sciences, hospital care, social welfare, labor and management will be invited to speak on a broad spectrum of problems relating to improved medical services, to stimulate free and open discussion of such problems.

### THE OCCASION

Fittingly, Michael M. Davis opened the lecture series established in his name by friends and admirers. He delivered this talk at Billings Hospital, the University of Chicago, on May 23, 1963.

I come before you with feelings of gratitude, hope and humility. Gratitude, to this University and to the friends and organizations that have brought this Lectureship into being; hope, that the annual occasions such as this will help to define timely ways in which the growing powers of medicine can be more effectively applied to human service; humility, recognizing the minuteness of an individual passing through the universe of science and touching the vast forces that create and direct social action.

Let me say in setting forth under the present title that I do not define "Challenge" as a call to battle between enemies, but as a bugle-note to allies to participate in efforts for a common cause. The intent is best defined by a little historical perspective, looking back as we now approach the final third of this Century.

### *The Pace of Change*

The striking fact of this Twentieth Century is *change*, the amount and pace of change. Population has been growing at a rate never before known. In the natural, the biological and the social sciences, the mass of knowledge has expanded in the past 60 years more than in all the previous millennia of human history. Technology—the ways men produce and distribute goods, services and ideas—has moved on the heels of science in dizzying interplay. In the more developed countries the preponderant rural life of the past has given place to urbanism. The political face of the world has been transformed since the First World War.

About 300 centuries ago, our far-distant ancestors in Europe faced the on-coming Ice Ages, with radical changes in climate and food supply

dozen brands of specially trained technical personnel to operate it. The hospital is no longer the last resort of the poor, but holds a premier place in the diagnosis and treatment of acute disease for all income groups.

Moreover, much medical care today is supplied by physicians who do not work as isolated individuals, but who are on full-time salary or who work through or under the auspices of an organization—a hospital, a clinic, an industry, an educational institution, an agency of government. At least half of all the income of physicians and hospitals comes now from insurance or from tax funds, not from fees paid by individual patients at the time service is received.

We can group the manifold changes into four types:

- I. Change in *Science and Technology* and consequently in practice and institutions.
- II. Increase in the *Costs* of medical care, medical education and medical research; both as to the capital investment and the current funds required.
- III. Growth of *Organization* under voluntary and governmental auspices (*a*) in medical services and institutions; and (*b*) in the economic methods of supporting them.
- IV. Increase in *Demand* for Medical Service; resulting from the enhanced powers of Medicine and from diffusion among the people of knowledge about these powers.

Today American Society demands that the beneficent powers of Medicine shall actually be available to all the people and now challenges Medicine to work actively and cooperatively with Society to attain this goal.

### *Medicine and Society*

As Medicine and Society work together towards this high purpose, they must recognize clearly their respective responsibilities and their large area of mutual responsibility. Medicine is challenged to recognize Society's primary responsibility for the social, economic and organiza-

tional policies affecting medical care. Society is challenged to accord to Medicine full freedom in the exercise of Medicine's distinctive professional responsibilities. Medicine and Society have the mutual responsibility of *adapting to change*: whether change arises from developments in science and technology, or from alterations in population or in social, economic or political conditions; or from any or all of these circumstances.

Thus the challenges of today fall both ways: from Society upon the providers of medical services, especially physicians and hospitals; and from Medicine upon Society, especially upon the organized groups that pay a substantial part of the costs, and upon the local, state and federal governments that spend billions and possess inherent regulatory power. We are all aware of the tensions that have arisen between the providers and the consumers of services. These tensions arise largely because change in conditions and needs moves faster than change in human attitudes. In America the appropriate way to reduce or remove tensions is through mutual understanding.

Let us explore a few concrete situations, each of which represents a sheaf of present practical problems.

### *Health Insurance, Taxation*

A generation ago, just before the great depression, less than 3 per cent of Americans had any health insurance. Today more than 70 per cent have some health insurance. Much of this insurance is inadequate, falling far short of covering for the individual the full cost of satisfactory medical care. Nevertheless, the principle of insurance—meeting risks which are unpredictable by individuals through spreading the risks over groups of people and over a period of time—is now accepted in America as a sensible way of paying for medical care. This growth of health insurance within 30 years is a revolution on the economic side of medicine.

Another group method of meeting sickness costs is by tax funds. Insurance and taxation are both methods of distributing risks unpredictable by the individual. In 1929, expenditures for medical purposes by federal, state and local governments amounted to a slice of one-seventh of a small pie of \$3.6 billion, spent for medical purposes by all private and public sources together. Today, the taxes spent for medical purposes make a slice of one-quarter of a huge pie of over \$30 billion.

### *Enhancing Consumer Power*

Both insurance and taxation have an important by-product affecting medical care. Group payment increases the power of the consumer. The \$7 billion paid for medical care through health insurance is spent by well people. They are not individuals buried in the anxieties of sickness. They are in a position to consider what they get in return for what they pay. Their power is enhanced when they act through organized groups, unions and employers. They can bargain with doctors and hospitals in the endeavor to get the most for their insurance dollar. They can also turn to their state or federal government, employing voting power instead of bargaining power.

A million-man union, the Steelworkers, recently employed an expert staff to study just what care the members are getting and how they can improve it through changes in their insurance plans and otherwise. Here the consumer is arming himself with the power of knowledge, not merely of numbers.

On our Pacific Coast a large employer, impressed with the contribution to productive efficiency made by competent medical care of his workers, took leadership in developing one of the largest and most comprehensive medical-care plans in this country. In several states, organized consumers have been roused by increasing costs

to demand state action by the agency regulating health insurance.

Organized groups of well people can offer challenges where sick individuals are helpless. The medical uses of tax funds enlist consumers as citizens of the body politic. Health insurance arouses them as non-political citizens and instigates their education on economic and medical issues.

### *Health Insurance Deficiencies*

Deficiencies in present health insurance supply them with many incentives. The indemnity insurance offered by the commercial companies has met a widespread demand for financial protection against major sickness costs; but its criteria are wholly financial. It cannot measure up to the basic medical criterion of health insurance—the inclusion and the encouragement of all needed medical care.

Blue Shield, managed by physicians, has limited the scope of its offerings mainly to illness in acute, short-term hospitals, and has overemphasized surgery. The medical societies which sponsor Blue Shield plans have rarely controlled an abuse which sometimes reaches gross proportions, that is, the patient is charged a higher fee than the stated tariff, when the doctor learns that the patient carries insurance.

Blue Cross has limited itself mainly to acute cases and has tried to meet the competition of the commercial companies by adopting the business policy of "experience rating," giving groups a lowered rate if age, sex and other elements indicate a lower sickness risk. Groups with many older workers, groups with many women, groups in unfavorable occupations need health insurance especially, but cannot afford high rates. When the needs of society are considered, the insurance principle requires spreading the risk not merely within favored groups but among all groups. Thus most Blue Cross plans have violated the

principle of community service on which Blue Cross was founded in 1933.

In health services the United States has developed something unique—the combination of the principle of voluntary prepayment with a form of professional organization that makes three important goals possible: (1) a comprehensive scope of service, (2) the promotion of high quality of service, and (3) the maintenance of professional independence within an organizational framework.

Some 4,000,000 persons now obtain such service through insurance plans which provide care through group practice. The unfortunate opposition of medical societies has not stopped the growth of these plans, but has slowed it.

It seems evident today that Americans want health insurance and that their wishes run from this general approach to two directions. First, the 138,000,000 people who now have some health insurance want more of it, that is, they want their insurance to cover a broader scope of medical services. Second, the 46,000,000 people who now have no health insurance want to have it, or else have tax funds pay for their medical care.

### *Challenge to Medicine and Society*

It is equally evident that these social demands present a challenge to both Medicine and to Society. Medicine, medical institutions, business and consumer interests are challenged to apply professional rather than economic yardsticks to the present forms of health insurance; to adjust Medicine's sponsorship and participation in health insurance plans accordingly; and to keep economics in its proper place in the perspective of a service profession.

What steps can be taken towards this goal? There are interdependent issues that must be explored before this question can be dealt with: the number, quality and organization of physicians;

the adequacy and the organization of hospitals and allied medical institutions.

Medicine is service, and in rendering any service, the people who provide it are primary. We have a large variety of providers, professional, technical, commercial, from the physician to the backwoods seller of snakeoil. Considering only the top figure, let us ask first: Does America have a sufficient number of physicians? In 1962 we had 247,000 physicians, excluding the 12,000 who were retired or out of medical work. The ratio to population was thus one physician to every 772 people. Is this number "sufficient"? What is the measure of "sufficiency"?

### *The Supply of Physicians*

We may make some comparisons with the past. In 1931 the ratio was one to 785. If we go farther back, we shall be surprised to find that in 1910 Abraham Flexner reported one "physician" to an average of 568 persons. Of course a large proportion of these men had brief and wholly inadequate training. Then one may contrast the composition of the profession today with former years. Even no farther back than 1931, general practitioners were nearly three-fourths of all our active physicians. Today, they are less than one-fourth. Sixty per cent of privately practicing physicians limit their practice to a specialty. The physicians on full-time salary have multiplied four times since 1931 and the interns and residents six times. Obviously the changes in functioning within the profession render the mere doctor-population ratio no close measure of sufficiency.

On the other side, the physician now has assistance such as did not exist awhile ago—nurses and aides on several levels, medical-social workers, six or more varieties of technicians. How much does this batallion multiply his lone right arm?

Furthermore, the sufficiency of the supply of

physicians involves the amount and nature of the demand for medical services. Without doubt this demand has grown in bulk and in breadth as the powers of medicine have multiplied and as popular knowledge of these beneficent and often dramatic powers has been spread through modern means of communication. More and more people want more and more from medicine. Therefore when we see that the physician-population ratio is now practically the same as in 1940, we are inclined to suspect that we need more doctors.

There are other kinds of non-statistical evidence which weigh in the scale. There is much conversation about the long time before one can make an appointment, in a non-emergency situation, to see a doctor in his office; and about the quarter-hour or more spent in waiting to see the doctor after you have arrived at the appointed time.

Is the increasing income of physicians, now at the top of the pyramid of the professions, further evidence that the supply is tight? Not a few physicians and surgeons seem to expect that their earnings shall enable them to move in the same circle as business executives whose salaries range from \$30,000 to \$60,000 or more. Is this a help towards the doctor's understanding of people who are raising families on \$3,000 to \$7,500 a year? It is not so much the large income, as the attitudes which often characterize the search for it.

During the late 1940's, when there was considerable concern about the "doctor shortage," President Truman supported legislation providing grants to help enlarge existing medical schools, to build new schools and to aid in their operation. A bill drawn with the aid of medical educators passed the Senate; but the American Medical Association succeeded in preventing it from getting through the House. There was no shortage of physicians, declared the A.M.A., and the proposed law was unwarranted federal interference.

This was more than a decade ago. Today, when President Kennedy is recommending legislation with similar purposes, the belief that there is a shortage of physicians is so widespread that opposition on the old grounds has almost ceased. The bill recently passed the House.

### *Quantity, Quality, Education*

Medicine should challenge Society today—and medical educators do—to provide the ample economic support required to bring medical personnel up to the number needed. Quality is involved as well as quantity; the subject-matter and methods of medical education as well as the number of students in medical schools. Of course, dentists, nurses and others are involved as well as the central figure, the physician.

"In modern life," wrote Abraham Flexner, 53 years ago, "the medical profession is an organ differentiated by society for its own highest purposes, not a business to be exploited by individuals according to their own fancy." Flexner said this at a time when crass commercialism dominated most of the 147 so-called medical schools then in the United States.

Flexner's Report, implemented by the American Medical Association and leadership by a few medical schools, brought within one generation the destruction of most and ultimately of all the profit-making schools. It put schools under educational auspices—schools imbued with the spirit of science, combining the diagnosis and treatment of hospital and clinic patients with didactic instruction and personal work in the laboratory.

A medical profession without recognized or enforceable standards, a profession in which only a few had adequate education, based often on study in Western Europe, gave place to a profession scientifically trained in America in medical schools and hospitals under university auspices. Furthermore, the responsibility of the profession for service to the public came to be expressed in

publicly formulated standards for medical schools, and for admission to practice in general medicine and in the specialties. The state boards of licensure and the private specialty boards express this responsibility.

### *Dangers of Overspecialization*

Flexner had to face what he called "the formidable combination made by ignorance, incompetency, commercialism and disease." Today we face the troublesome combination of overspecialization in acute disease and relative neglect of the diseases and impairments that persons must live with. We face problems brought by industrialization, urban life, the automobile, the airplane, the new arts of communication, the altering composition of the population and the advancing preventive and rehabilitative powers of medicine itself. Let me give a couple of illustrations.

A middle-aged man slipped on a ladder while doing repair work at his suburban home and fractured his right wrist. His family took him at once to a surgeon qualified by long experience and the diploma of the American Board of Surgery. After checking the fractures by fluoroscope, he set the bones under anaesthesia. The subsequent X-ray reported a "perfect reduction." The forearm and most of the hand were put in a cast. The surgeon saw his patient once before the cast was removed six weeks later. He said nothing to his patient about exercise of the fingers while the cast was on. A deformed fore-finger resulted, despite long but too long delayed physio-therapy, initiated by a friend of the patient. The surgeon gave all his attention to the broken bones; none to the maintenance of function.

An obese woman of 32 was admitted to a teaching hospital because of prolonged intestinal symptoms which her family physician had been unable to alleviate. Extensive laboratory and X-ray studies led to a diagnosis of diverticulosis. Surgery was not advised and no advice was given the patient except care in diet. No attention was paid to a tense family situation, a husband profoundly dissatisfied because of his wife's failure to bear any children; the wife at first seeking satisfaction in food, later frustrated by increasing dissensions. The culmination was her suicide. The specialists had focused wholly on this woman's body. They ignored the woman.

The hospitals in which medical students, interns and residents are taught are organized by specialties; the medical school's faculties are organized into departments according to specialties. Each department competes for as much time as possible in the curriculum. The student is taught mostly about disease. The intern and the resident make a series of cross-section studies of acute disease, rarely any continuing observation of persons, even of persons who need to learn how to live effectively with their diseases.

To this sort of problem, sciences which are not within the curricula of most medical schools have contributed a great deal during the post-Flexner period. These are the sciences of individual and group behavior: psychology, anthropology, sociology. Economics also sheds light on one major set of human motivations, involving patients, doctors and hospitals. Psychiatry is within the curriculum, and it penetrates human behavior, but in private practice mostly the abnormal.

Nostalgically we turn back to the old-time family physician, glorified in the mists of years. Were the limited powers of the medicine of his day balanced by his knowledge of his patients as persons, as families, as members of communities? Often he gave satisfaction as a counselor and comforter, practicing a human art learned though never taught. The modern doctor can often give satisfaction by curing disease which was beyond former powers; but the changes in the age constitution of the population, along with the new powers of preventive and rehabilitative medicine face today's physicians with more and more health issues, the resolution of which is found less in the laboratory than in inter-personal relations and social action.

The emphasis on research in many top hospitals and medical schools has re-enforced the tendency to focus on tissues and organs rather than upon organisms and persons. The dean of a new medical school said to me proudly: "The mem-

bers of this faculty were picked because they are scientists." The status of scientist has its glories; but medicine's ultimate responsibility is people.

### *Include Sciences of People*

Medical education must in no wise relinquish its science; but it must broaden its concept of science to include the sciences of people. It must recognize furthermore, in theory and practice, that knowledge of people and ability to deal with people depends upon continuing observation of individuals as well as upon cross-section studies. It can gain the needed continuing observation in several ways, especially through larger use of the out-patient department and through attention to the neglected institutions housing "chronics."

The reform of medical education stimulated by Abraham Flexner was of gross evils, indefensible when revealed. The reform needed now calls less for destruction of positive evils than for the establishment of a better balance among areas of the good. Today medical education is too much insulated from popular understanding, although the issues at stake affect the lives of millions. There is crystallization in institutional trend and structure; and also in minds that resist change, particularly when change comes from what is called "outside." Society is outside Medicine, but only as the foundation of a house is outside the living rooms.

Society now challenges Medicine to readjust its professional education in medical schools and hospitals, so that physicians shall be better prepared to adapt to changes in practice, as they have adapted to changes in science; and so that physicians shall have fuller understanding, obtainable from science, of the personal, economic and social elements in disease and incapacity.

### *Transformation of the Hospital*

The development of technology has been the primary though not the only force which during the present century has transformed an ancient

institution serving as a haven for the sick poor, to an agency which may be a center of medical service for all. With the advance of specialization among physicians and allied vocations, of the arts of surgery, of laboratory services, of the X-ray and of the increasing capital investment needed for diagnosis and treatment, the hospital has come to possess facilities and personnel that are not available anywhere else. During the first quarter of this century, our general hospitals underwent three revolutions, one medical, two economic.

Medically, the fully developed hospitals assemble in one place all the specialized personnel, all the elaborate equipment, and part of the organization needed to apply science to service in acute illness.

As an economic consequence, all sections of society—wealthy, middle class and poor—came to use hospitals, for almost no homes can offer the acutely ill person the services the hospital can. The economic support of the hospital consequently became no longer primarily charitable. The patients' payments became the primary source of support, at first payment in fees by individuals, now more than half through insurance. The amount and proportion of tax support grew also.

### *Private Practitioner in the Hospital*

A second economic revolution is less obvious but is not less important. The ancient tradition of unpaid service by the medical staff made no sense in the new economic situation. Physicians and surgeons thus came to work in American voluntary general hospitals primarily as private practitioners, paid by their patients directly or through insurance. Except for the minority of hospitals directly associated with medical schools, and the governmental general hospitals designed for patients of small means, the patients segregated in "wards" constitute only a small fraction of the beds. Thus the typical American general hospital,



a non-profit, non-governmental institution, has become a place provided by the community for the private practice of medicine on bed cases.

How large is this community gift to the private practitioner in the non-profit hospital? We do not know the exact number of beds in voluntary non-profit hospitals which are assigned to private practice; nor the exact number of physicians who carry on private practice in these hospitals. I have made some tentative estimates to the effect that about 150,000 physicians carry on some private practice in about 330,000 community hospital beds. This would mean that each of these doctors uses without charge an average of some \$44,000 capital investment; and in addition each such doctor has the use of professional and technical services (not counting interns and residents) worth over \$10,000 a year.

Is there anything wrong with this system? It is almost unique among the countries of the world, and we have become accustomed to it as we have to hot weather in July. Whatever a field study might determine the accurate figures to be, it is worth having in mind that the community gift to private practice is certainly no bagatelle. How many physicians are conscious of this gift and of its implied obligations?

The dominance of private practice in many general hospitals affects hospital policies and community relations. The system focuses on short-term bed cases. Hospital policy, so far as medical-staff interests are concerned, focuses mostly on episodes of disease, not on the continuous and comprehensive care of persons. The vastly increased preventive powers of curative and rehabilitative medicine that have developed during the Twentieth Century for other than bed cases—mostly pass by the average hospital.

We have not yet reorganized the structure of our medical service to correspond with the changed realities. A majority of our hospitals have no out-patient departments. Those which have,

generally limit them to patients unable to pay for care in a private office. In out-patient departments, such patients obtain care in specialties, often without any more informed coordinator than the patient himself.

In private offices, care is largely by patient-selected specialists, in separated locations, with independently kept records, and only such coordination as the wisdom of a personal physician may call forth. We have allowed the majority of our nursing homes to grow as commercial units and the patients in hospitals for chronics to be dubbed by many physicians as *uninteresting*.

In the huge and slow task of re-orienting personnel and institutions, we can find some comfort in beginnings made in several major cities, where Hospital Councils or Hospital Planning Associations have been established to study area needs, formulate community plans and be able to influence the flow of private and public funds towards projects that fit the plan rather than personal or institutional ambitions.

### *The Central Problem of Organization*

The problem is partly one of such planning, so as to obtain the maximum medical values from the capital investment in hospitals and allied institutions. The problem also involves intra-institutional organization, particularly the medical unification of in-patient and out-patient departments and their administrative coordination towards the end of comprehensive care of high quality. Forty years ago, the Presbyterian Hospital of New York and the Committee on Dispensary Development worked out these inter-relations in practice and incorporated them into principles which were accepted by the American Hospital Association; but medical and institutional trends have kept them from being generally applied.

Both community and institutional aspects, taken together, constitute the central problem of

medical care today: the organization of services towards the goal of continuous and comprehensive care of persons. Society challenges Medicine to organize its specialisms and its institutions so as to obtain comprehensive care of persons, coordinating generalist and specialist, bed and ambulatory, acute and chronic, diagnostic, curative, preventive and rehabilitative. We might put this more briefly by saying that Medicine is challenged to adapt the organization of its services to the requirements of its own technology.

The obstacles in the way are ideological and economic. They include institutional structure, professional habits and popular ignorance. Physicians must learn—as some have already—that, partly in return for the community gift of hospital resources, they owe responsibility for the overall care of the patient as well as for the diagnosis and treatment of a disease. Many of the business men who largely govern hospitals need help to learn to look beyond the special interest of “their” institution. The unions and employers that manage many insurance funds need to use their bargaining and financial powers to support community and regional planning. The Community Service Committee of the AFL-CIO has recently issued a report touching many phases of this subject effectively. In general, the economic interest of consumers is for planning and coordination. The immediate economic interests of some doctors, hospitals and allied institutions seem to be against these policies.

The basic problem of medical organization in America is to organize services and institutions with the objective of the care of persons rather than of diseases. Of course the care of disease is included within the care of a person. The doctor who treated “anybody for anything” is gone for good, because the mass of medical knowledge and skills is now far too great to be mastered by any one man. Specialization has become necessary, but detached and un-coordinated specialists

lead to the fragmented and impersonal service of which many persons complain today.

The advantages of specialization, however, without its disadvantages, can be had through proper organization. The personal or family physician can be brought back into the life of all Americans, but only by extending a correct organization of medical services. He cannot be revived as an individual practitioner, in the urban and suburban areas in which most of us now live. Our personal doctors must be members of organized medical groups, each including also a variety of specialists. Each of us would choose a local medical group and our personal physician from within that group, and would have continuing contact with that physician. That physician would see that his patient receives whatever attention is needed from specialists, and he would coordinate the work of the specialists. This is *the personal physician in his Twentieth Century form*, made necessary by the complex technologies of specialism, laboratory, and therapy. This is specialization organized for personal, continuing, coordinated and comprehensive care.

### *The New Personal Physician*

This is not a dream. The personal physician in his Twentieth Century form is now brought to some 4,000,000 Americans who obtain their services through properly organized physician groups, supported by prepayment. Some other Americans obtain it also, who are lucky or wise enough to select a physician who is willing and able to be their continuing coordinator. Such a physician however must take time and effort to overcome lack of organization. We need organization which facilitates rather than hampers the attainment of the necessary goal.

Group organization of services should be extended, through hospital staffs, group practice clinics, and otherwise, so that comprehensive and coordinated medical care shall thus reach all

Americans. America challenges Medicine to help realize this goal.

### *How Make Progress?*

May I in conclusion turn from policies and principles to a practical question: How are we to make progress? What forces can be brought to bear to move things as they are towards things as they had better be?

There are many present forces which now make for progress. There are some that work against progress. Do we need to create some new forces, medical or social?

The powerful and pervasive force which has operated and will continue to operate is the advance of medical-care technology. Thus far, technology has usually increased the specialization of personnel and equipment and the elaboration of procedures; and this type of change necessarily brings need for an increase in organization.

The growth in salaried physicians and in services supplied by physicians through institutions is one of many illustrations. It is true that the focus of the technological organization needs to be shifted from diseases to persons. There are also advances in technology which have simplified procedures at least as much as elaborated them. Antibiotics have obviated many mastoid operations. In general we can be confident that technological change will continue and that it is easier to re-direct a situation that is full of change than a situation which is static.

The enlarging power of the consumer through his participation in group payment—insurance or taxation—is a continuing force in the right direction. The voluntary system of hospital accreditation and planning has shown its values and also its limitations. Forceful political leadership must protect the public against hospitals that will not seek or cannot obtain accreditation. Legal status of state and regional planning bodies is necessary and can be established without loss of effective

voluntary participation. Consumer demand should remove laws in some states, restricting group practice plans, and laws overweighting medical-society or hospital influence in some insurance plans. Public grants to medical buildings and equipment should include aid to group practice plans meeting satisfactory standards. We should set a pattern of national financing for the institutional care of the aged through Social Security, keeping this primarily a financing mechanism, not a national management of services. None of these measures is costly, when existing wastes are counted against new outlays.

The support of general hospitals through insurance and taxation has become so extensive and the advantages so apparent to so many people, that the time is ripe for the formation of public policy in this area. We have tested out good American methods whereby nobody need hereafter be beggared by hospital bills. We are delinquent if we don't put these methods fully to work for the people they don't reach now. In some states, Blue Cross and other insurance plans, plus local and state use of tax funds, take us most of the way already. In other states there is a long way to go. Voluntary and legislative action would be stimulated if labor and industry would formulate a national objective, that health insurance should be universally available.

The problem of financing hospital costs is simple as compared with physicians' services, where tough problems of quality and organization are interwoven with the economic problem of paying for care. I do not want us to go into a universal scheme of governmentally organized and financed medical service. The United States is large and its localities vary widely in resources, customs, medical facilities and needs. We shall do better to continue as we have, by functional experimentation, some voluntary, some governmental. Widely understood objectives would encourage and guide experimentation.

## *Need for Medical Leadership*

Our great lack at this point is affirmative medical leadership—leadership which would define positive goals, consistent with evident changes in the substance of medicine, in technology and in social and economic conditions; a leadership which would also participate in working out steps towards these objectives consistent with the quality of the profession and of its services.

I do not need to dwell upon the negative record of the American Medical Association and most state and county medical societies. A half century of experience does not prevent surprise, sorrow and anger when I read the one-sided statements and the misinterpretations of fact offered physicians by their national professional agency in its campaign against hospital care for the aged through Social Security. The same standards of impartiality and accuracy that characterize the A.M.A.'s scientific articles do not obtain in its articles dealing with the economic and political aspects of medicine.

There are many physicians who deplore the A.M.A. policies, but except on a few occasions, in a few county and state medical societies, they have not been numerous or effective enough to alter policies through the professional bodies.

As individuals, such liberal physicians have given essential assistance and often leadership in improvements in medical and hospital service, usually working with lay bodies. But our country lacks a liberal medical voice, the weight of whose words would depend on what was said, not upon how many said it.

### *A National Physicians' Committee*

We need a Committee of Physicians for Progress in Medical Care, which might be a body of from 100 to 250 physicians, spaced functionally and geographically.

Such a committee would define goals of medi-

cal care adequate in scope, quality, and organization; would analyze and appraise selected plans existing and proposed; and would comment on controversies and controversialists when necessary.

Experience suggests the advantages of having such a committee formed under the auspices of an existing nationwide, non-political body—the National Social Welfare Assembly, or the Committee for Economic Development, for example. The effectiveness of wholly self-contained national medical committees has not been encouraging.

Of course there would be attacks, open or insidious, against physician members of such a committee. Association with a nationwide lay body of standing would aid in protecting them and in forcing responsibility on their critics. Another value in a positive medical voice would be help against the embitterment of public opinion towards organized medicine, which might introduce a punitive quality into legislation.

It is not my purpose, nor is there time, to enlarge upon the details of this idea. I present it because I believe that were such a committee in operation, thousands of organizations—unions and cooperatives, industries, farm groups and public agencies—would be able to feel a sense of purpose and direction whereas now they grope towards improved forms of medical care. Understanding a goal, or the next step toward a goal, mobilizes power.

### *Reasons for Hope*

May I make a final and doubtless not a surprising announcement. I am an optimist. My reason for optimism may be partly temperamental; but it is also based on a fact; namely, that the changes I see needed ahead are less than the changes which I have seen actually take place during the last forty years. I am aware that resistive powers have been developed by some professional cells against

the antibiotics of change; but I believe the demand of millions of Americans for access to the full and growing powers of medical care has already reached a point where it will not be denied.

The people need help in defining goals and next steps; but they are on the march. America challenges physicians to accept the primary responsibility of the public in deciding how the people will spend their money for medical care, and asks physicians to cooperate, as only physicians can, in working out the organization and the ways of payment that will conduce to the scope and quality of the care as well as to the economics of the patient. Medicine seems to be stepping its potential values up to a higher and higher level with every decade. Let us work with plan and steadfastness so that the mutual responsibilities of Medicine and Society will be exercised with the foresight, wisdom and restraint which will bring these potentials fully into the lives of everyone.

