The New England
Journal of Medicine

Volume 236 JUNE 19, 1947 Number 25

ANNUAL ORATION

MEDICAL CARE IN OUR FREE SOCIETY*

LELAND S. McKITTRICK, M.D.†

BOSTON

The objective of adequate medical care in our free society is to make available to everyone — regardless of race, color, creed, financial status or place of residence — every known essential preventive, diagnostic and curative medical service of high quality. The attainment of such medical care must necessarily be an evolutionary process which will require the co-operation of all concerned over a period of years.[1]

I have chosen as the subject of my oration this paragraph from the *Basic Principles Which Should Govern Medical-Care Plans*, which the Massachusetts Medical Society presented last year. Concise and complete, it stands as a challenge, if not a commitment, to us as members.

Available to Everyone Regardless of Financial Status.

Financial status as applied to medical care is a relative term. To the head of a household, modest but sound, the cost of an appendectomy for one of the children may be met without undue hardship. Should the head of this household suffer a long and serious illness, the unavoidable financial obligations assumed may represent a burden that not only is a hardship but also may be overwhelming.

A consideration of the availability of medical care to the people of this Commonwealth must include a study of the income of the prospective recipients as well as of the cost of the services rendered. Interested in and busy with the calls of our patients, few of us have given thought to the earnings of the people of the Commonwealth that we as a profession serve.

It has been with much greater difficulty than would have been anticipated that information was obtained that might give us some reasonably accurate data on the relative number of workers in this state who fell into the different income classes.

Figure 1 is based on data compiled by the United States Treasury Department.‡

Whereas wages in 1942 were at a lower level than those of the present, the wage earners' income was probably higher because of overtime and other incentives used to increase production. To me, this is an impressive picture. It must be kept constantly in mind as we discuss the problem of a program that will make good medical care available to all the people of the Commonwealth.

Good medical care is and will remain expensive, but the continued rising costs of this care are a concern to us all. Yet there must be a ceiling to such costs, or else they cannot continue to be met by too large a segment of our population, and the price put on good health will be out of proportion to that on other necessities and privileges of our daily life.

As one might expect, most of the increasing costs are in hospital and nursing care. Thus, in 1940 the average total per-diem hospital charge, exclusive of professional and special nursing care, to 100 patients in the lowest price accommodation at the Baker Memorial Hospital was $7.31, and in 1947 this same care cost the patient $13.40 daily, or $93.80 per week.

What are the factors responsible for this, and how are they being met? The financial problems of the voluntary hospitals were presented in a forceful and realistic way by Dr. Faxon[2] in his address at the Ether-Day Exercises last October. Two months later, the Hospital Council of Boston, after careful deliberation, recommended that the hospitals of the Greater Boston area adopt a pay-as-you-go philosophy for meeting rising costs and diminishing voluntary contributions. Specifically, the Council recommended that in the near future hospital rates be

*Presented at the annual meeting of the Massachusetts Medical Society, Boston, May 20, 1947.

†Associate in surgery, Harvard Medical School; surgeon-in-chief, Palmer Memorial Hospital; surgeon, New England Deaconess Hospital; visiting surgeon, Massachusetts General Hospital.

‡The basis of the data is Table 8, which presents individual returns with net income for 1942 by taxable and nontaxable returns and by net income classes, and also aggregates, by states, for individual returns with no net income and for taxable fiduciary returns with net income.

established at such a level that they would approximate the cost of hospital care and suggested that in this community a rate of $8 a day plus extras, or a total of about $11 per day, be established as the minimum ward rate, with the understanding that those unable to pay the established rate be admitted as before for whatever they could pay. These rates were promptly accepted by most of the hospitals in the Boston area. If special nursing and professional fees are added to the $11 or more a day and it is considered that in 1942, when earnings

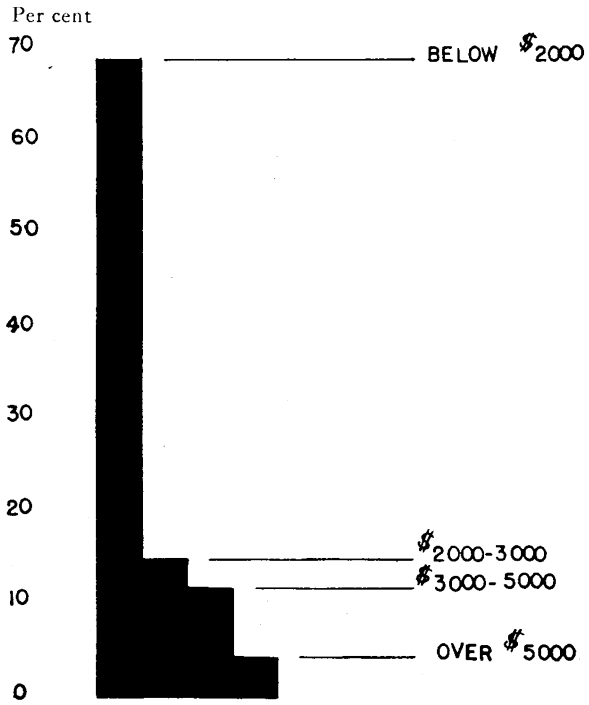

FIGURE 1. *Net Incomes by Classes for Massachusetts*, 1942 (*from* Statistics of Income for 1942, *compiled by United States Treasury Department*).

were up, 69 per cent of the wage earners of Massachusetts had a net income of $2000 or less and 84 per cent received less than $3000 a year, it becomes at once obvious that the phrase "regardless of financial status" assumes real significance.

Let us for a moment consider the present high cost of hospital care. This is highest in our large teaching hospitals largely because of the overhead associated with research and other activities intimately tied up with medical advances and the teaching program. To eliminate these activities is to strike at the soul of good teaching and medical progress and is not to be considered. Still this is extremely costly. How can these institutions continue to meet the costs? Surely not by raising the charges for hospital service to the relatively few private patients cared for in these hospitals; nor should the same patients be expected to pay for it indirectly by having a portion of the professional fees used for this purpose. The results of these investigations benefit all prospective patients, not only in the hospitals in which the work is done but also in and out of all hospitals everywhere. The organization and execution of this work is the responsibility of teaching hospitals with adequate and well organized personnel and physical facilities. The financial responsibility in the past has been almost wholly assumed by private benefactors. Ideal as it is, this source is uncertain and is becoming more and more limited. Additional, more dependable sources (including federal funds) must be and are being sought and obtained. Although such money may well be given for a specific project, these grants should and must be complete and free from all obligations — moral or otherwise. At the same time, it is incumbent on these institutions to review their organizations and to be in a position to assure prospective donors that money so received is being used with the greatest possible efficiency — lest too much of what is available go into reduplication of effort, disorganized investigation and ill conceived and overlapping laboratory expenditures. Research well organized and efficiently done must continue to develop for the benefit but not at the expense of the sick patient alone.

Patient care, on the other hand, is the responsibility of the persons requiring hospital care and of the communities in which they live. If this is true and if in the future our voluntary private hospitals are to be supported by those who use them, is it not proper to ask whether or not our present hospital services are economical, efficient and a pattern to follow in future planning? In other words, what are the responsibilities of the hospital to the patients it accepts and now charges full payment for services rendered? Where do special nurses at $25 or more a day fit into a program of such hospital care? Should they continue to be desirable for most patients undergoing routine major operations, even though in many of these cases their value to the patient and to the surgeon is in the constant attention to simple details in contrast to the experience, training and skill essential to the care of the more complicated conditions and the critically ill patients? Should special-duty nurses, as we now know them, offer a purely luxury service, except in cases in which they are assigned and paid for by the hospital to give the complete coverage that is necessary for the more seriously ill patients? Has not the time come when our concept of hospital service to the patients in semiprivate and ward accommodations requires careful and thorough revision and the adoption of a long-range program that will spread the cost of this care, regardless of the amount involved, over all patients entering the hospital?

The present shortage of nursing care is not pertinent to this discussion. It is here today as it was after the last war, and there is no immediate solution to it. We shall continue to live from hand to

mouth until there is stabilization of all labor at a more nearly normal level. We are greatly concerned, however, over the increasing demands for and the rising costs of nursing and over how these are to be met in the future. There must be and there is a solution to these needs, which can and will be worked out by a carefully planned and executed program and which has as its incentive one objective — the welfare of the patient rather than the continuation or extension of any existing patterns. Thus, there is much reason to believe that the present three years' training program leading to the R.N. degree is unnecessarily long and costly for preparing a young woman to carry out a large segment of bedside care, and that it is not adequate to develop a truly professional teaching and supervising personnel of high quality. Some breakdown, then, of our present concept of nursing care may be necessary. Just what pattern shall be followed may well depend on such experiments as are being carried out at present at the Massachusetts General Hospital, where a group of "earn-as-you-learn" hospital aids are being used under careful supervision for the routine bedside care of patients on two of the surgical wards. Possibly, as has been suggested, we should have three groups involved in our hospital nursing services: first and probably largest, young women and men trained for relatively short periods — probably not to exceed one year — to carry the burden of routine bedside care; secondly, young women and men with an adequate but not overscientific background, trained to care for the more complicated and critically ill patients — a training that quite possibly might be condensed into less than the present three-year period; and finally, a group of truly professionally minded and trained young women, whose responsibilities will be the supervision of our wards, the development of nursing programs and the teaching of the nursing personnel at all levels.

It is believed by many that 60 per cent or more of bedside nursing can be done by young women and men with the relatively short period of training. Whereas the more complicated operations such as those on the thoracic viscera and the brain are being done in increasing numbers and require constant and skilled nursing, the care of routine general surgical patients (and, I suspect, of medical patients too) has been simplified, not complicated, by recent developments. What so many of these patients need for a few days is attention, not complicated professional care. If this is true and if, as many experienced physicians believe, the bulk of routine patient care can be done by young women after short periods of training, is it not conceivable that by lowering the over-all cost of caring for the uncomplicated hospital patients and increasing the coverage given to those critically ill, a concept of hospital care could be developed, the cost of which to the individual would be well below that of the present plan if one includes the almost routine use of special-duty nurses, when they are available, in the early days following operation? But whatever method may be developed, surely at least a part of the high cost of hospital care must be met by a changing concept of what hospital service means to the patient seeking and paying for it.

An important, if not the most important, factor in the development and final success of any plan conceived and adopted by hospitals for the more efficient and less costly care of sick patients will depend on the interest and co-operation of the medical profession. Who, for example, shall decide whether a patient requires special attention or not? Surely not the hospital administration alone. You, the physician, better than anybody else know the condition of each patient, and extra services to those patients (exclusive of the luxury group) must be determined not on the wishes of patients or their families but on the condition of those patients in relation to the routine service that your hospital is able to give. Therefore, with the changing concept of what is best and most efficient for the care of our patients, let us take an active, aggressive and co-operative part in the development and execution of any constructive program that our hospitals may choose to establish.

Better routine care to the uncomplicated case with complete care to the seriously ill at the lowest possible cost that is spread among all patients entering the hospital in ward and semiprivate beds is, I believe, the objective toward which we should work.

But more inclusive and complete hospital service at the established rate is but a part of the answer. The over-all cost of good medical care will always be high, — too high for 84 per cent of the people of this Commonwealth to pay for out of pocket when the ax falls, — and it would be unfortunate indeed if any member of this Society failed to accept this as an integral part of his basic thinking. When you have accepted this, the inevitable question of compulsory versus voluntary coverage follows. There never has been and there is now no controversy between most of the proponents of the two methods over the objective, but there is complete divergence of opinion concerning the method by which that objective can most satisfactorily be reached. No one of you, nor I, nor anyone at this time has the vision to look into the future and say, "This or that is *the* method of paying for and distributing to the people of this country the highest possible quality of medical care." Whether we have voluntary or compulsory insurance will not of necessity depend on which is the better method but rather on what the people want. What the people want will depend on what proponents of a given method tell them as compared to how we as physicians lead and serve them. The proponents of compulsory insurance are now devoid of any favorable comparison. Medicine in England and Germany long ago ceased to favor it. Selective Service

statistics have been debunked. The United States Public Health Service, long cited as a Government agency efficiently run and free from any political pressure, fell from grace when each of its officers, including those in the Reserve, was instructed by the Surgeon General of the Service[3] to familiarize himself with the President's message (September 6, 1945) and to be guided by its provisions in any "public statement likely to be interpreted as representing the official views of the Public Health Service." And the public school, so often referred to as representing a form of taxation effectively returned to the people as public education, is no longer pointed to as an example of the efficiency and flexibility with which Government meets changing economic conditions. Devoid, then, of examples, the proponents must depend on theory, organization, propaganda and promises. But do not underestimate the logic of compulsory health insurance. In theory, on paper or over the air, it has everything. You and I, as practicing physicians, know that the problem is anything but as simple as Mr. Falk, Senator Pepper and others would have us believe. Not only do we as a group deliver to the people of this Commonwealth the greater part of their medical care, but also we, better than anyone else, know the problems. We know what keeps us on telephone call and what gets us out in the middle of the night, as well as what the people want, need and have a right to expect of their doctor. If this is true, should it not be possible for us to do our job as physicians and, in addition, to convince the people we serve, not only by valid argument but also by the effectiveness and sincerity of our efforts in their behalf? Are we not, by example, in a better position to reach the people of our community than those who must depend on words and promises alone?

We can be grateful to the Council of the Society for its wisdom and foresight in setting up the medical-care program as expressed through the Blue Shield. It is gratifying to learn that two million, or 50 per cent, of the residents of Massachusetts are now enrolled in Blue Cross and that Blue Shield had increased its membership by 108 per cent from January 1, 1946, to January 1, 1947. Both are to be congratulated on their rapid growth and their new comprehensive plans, effective on June 1, 1947; whereas there are some controversial points in the new Blue Cross coverage, these can and will be satisfactorily adjusted. It might not be amiss, however, to remind the directors of these services that they are a necessity for 84 per cent of the wage earners of this Commonwealth, but only a convenience to the remaining 16 per cent, and that any pressure from or desire to increase the appeal to the latter must not result in excessive cost to those they have been created to serve. These services must continue to grow and develop. Unless we as physicians have constantly before us the best interests of the people of Massachusetts and do our utmost individually and collectively to make possible better and better care through individual efforts and an aggressive, co-operative medical-care program, we shall have failed not only in our duty but also in our opportunity. The time is past when any but the well-to-do can pay for a serious hospital illness when or after sickness occurs. Prepayment for hospital and medical care for the people of this Commonwealth is here to remain. Whether it continues to expand and progress and to develop on a voluntary basis with its many possibilities or whether it is ultimately placed on a compulsory basis with its inefficiency and governmental regulation is up to us.

Regardless of Financial Status.

There is a large group in this, as in every state, who can pay for little or no part of its medical care. It will vary in size, depending on economic conditions and other factors. This is a large and an important group, and provision for its care is, according to our principles, the responsibility of the local or state government with the help of charitable agencies and if necessary federal grants-in-aid to state programs. Many are honest, frugal people who pay their normal way but have no savings or no prospects for meeting abnormal expenses. Others have never met and will never meet any obligations. A medical-care program that does not include this group is not complete and will not permanently survive.

Every Known Essential Preventive Diagnostic and Curative Medical Service of High Quality.

Prevention of disease is the first fundamental of good medical care. The Commonwealth is favored with a public-health department of unusually high quality. To Massachusetts in 1869 went the honor of establishing the first state department of health in this country. In spite of its seventy-eight years of progress and its excellent record, however, over half the citizens of the Commonwealth are deprived of the benefits of the latest developments of medical science and preventive medicine.[4] Until all the communities in the Commonwealth are covered with full-time medical health officers with special training in public-health work, until such men are given adequate compensation and until there is real co-ordination in all the public-health work of the Commonwealth at both state and local levels, preventive medical service of high quality will not be available to all the people of Massachusetts.*

Diagnostic and curative medical care go hand in hand. Far too much has been said in recent years about the cost and distribution of medical care, and much too little about the quality of services given. Both are important. Both must be developed. But unless the quality of service given

*Every member of the Society is urged to read the excellent survey of the program of the Department of Health referred to above.

is constantly improved, its distribution and the methods of paying for it are of little significance. You and I, who in the past have thought largely in terms of doing our daily work to the best of our ability, must now give thought not only to our patients but also to the organization and the development of our hospital and professional facilities to provide medical services of higher and higher quality, as well as to the development of organizations that make these services available to all the people of our communities. Fewer patients should come to our larger cities for care that can and should be given in their own community.

What, then, are the most important factors in a medical-care program whose object is to offer to a given community the best possible medical service, and what are our responsibilities as physicians in the development and utilization of these various factors?

A modern hospital of adequate size with an active, effective and co-operative governing board and an able, well organized professional staff are essential for a medical-care program of high quality.

Completely to fulfill its place in the community, the hospital must be the center of health activities. It is not enough that this hospital is of modern construction, well equipped and soundly financed. It must, in addition, be of sufficient size, preferably two hundred beds or more, although in many communities excellent, if more limited, medical and surgical services are being offered in smaller units. With few exceptions, however, hospitals with less than two hundred beds are dependent on larger institutions or outside personnel for many of the services essential to diagnosis and treatment of even the more frequent conditions. Also, the smaller the hospital, the more limited the staff and its clinical experience.

It has been suggested that a hospital of approximately two hundred beds can be efficiently maintained and offers sufficient clinical and laboratory material to assure well trained full-time radiologic, pathological and laboratory personnel. Moreover, the number of patients cared for is adequate to attract young men of ability and with proper training to assure a professional staff of high quality. I see little justification for the erection of general hospitals of fewer than two hundred beds except in rural areas, of which in this Commonwealth there are relatively few. How much better to follow the lead of the people of Newton and Wellesley and have adjacent communities join in the erection and maintenance of a plant of adequate size to be completely self-supporting and self-sustaining!

The trustees or governing bodies of our hospitals have a broader responsibility than the building and maintaining of the physical plant. One may well ask whether or not such a board is justified in urging a community to raise a large sum of money to erect and equip a modern hospital unless it is prepared to support, to encourage or, if necessary, to insist on the development of a staff organization that will assure a quality of care in keeping with the institution to be built and supported. There is too often lack of co-operation between the trustees and the professional staff. Only by continued exposure of each to the problems of the other can there be proper understanding. Without this, no lay person, no matter what his interests, can appreciate the many practical problems of the physician in the care of his patients, and only by a better understanding and closer co-operation between trustees and staff will it be possible for modern hospitals to function with their greatest efficiency.

Given proper facilities in which to work and a responsible, co-operative governing board, the quality of medical care is dependent on — in fact, is — the complete responsibility of the medical staff. We share with no one the training and experience necessary to develop for the people of our communities the high type of medical care to which they are entitled. Our American way of free enterprise has placed high award on individual initiative. Medicine, by its very nature, has encouraged in every way the development of the individual instincts in all of us. No one can ever criticize the great mass of American physicians for any lack of personal application to their professional work. But the many advances in medical knowledge and the increasing complexity of medical care require more than individual application if patients are to be assured of the best possible care. Medical care of high quality is the end product of combined and well co-ordinated efforts. It has as its objective the welfare of the community as a whole, as well as of the individuals within the community. What is for their benefit will prove to be to our interests. It is no longer possible for anyone — no matter how capable, well trained or conscientious — to give complete medical care to any segment of his community, nor is it necessary that he try in so enlightened a state as ours. The co-ordination of individual efforts through group organization or within the well organized staffs of our community hospitals is, then, the guide to our professional development.

In the great proving ground of America, group medical care of every kind has been highly developed and is being successfully carried out. It remains for us in our various communities to select and develop the particular type that best suits our needs. Whatever the pattern, whether it be as a closely organized specialty group as exemplified in this community by the Lahey Clinic, or whether it be the more frequent, loosely knit organization of the entire professional staff around its hospital, as probably most highly developed in the Commonwealth at the Baker Memorial Hospital, there are certain requirements that are essential. It must offer the development of major and, when possible,

minor specialties, with the head of each department certificated by his respective board; recognition of and encouragement to general practitioners (except in certain specialty and teaching hospitals); assurance of a continuing high quality of care through the institution and development of a teaching program; and facilities for and frequent use of unrestricted consultations.

The development of an effective staff organization (and for the moment I will restrict my comments to the surgical staff) that will attract well trained young men to our communities, assure them of an opportunity to develop and co-operate in the medical-care program and utilize the established personnel but at the same time develop a spirit of pride in and loyalty to the hospital and through it to the people of the community, rather than one of ownership in and jealousy of the hospital privileges that they enjoy, is a truly challenging responsibility. The people of this Commonwealth owe much to the hundreds of excellent surgeons who have learned surgery by long and continued application over the hard road of experience. Without them, surgery could not possibly have developed to its present high standard, and thousands of people in this Commonwealth would have been denied the relief that has been theirs through the untiring work of these men. But the advances in surgery over the twenty-eight years that I have been a member of this Society beggar our imagination. No body cavity, no viscus, is exempt from safe surgical approach. Resections of the stomach, colon or rectum are now carried out by our senior resident staff with a competence and safety that even ten years ago we should have thought neither practical nor possible. These advances have not just appeared. They are the result of continuous study and application of men in our teaching hospitals and their laboratories in co-operation with the laboratories of our medical schools. There have evolved new principles and a more thorough understanding of the old. Surgery has become too complicated, too all-inclusive for a young man to learn as a part of his daily medical practice or solely by association with an older man. The surgeon of tomorrow will be trained in the larger teaching hospitals of today and in the institutions that are developed tomorrow. Only by continued study and limitation of all his thoughts and efforts to the work of his choice can the surgeon of the coming generation expect and receive recognition by the governing boards of the hospitals in our larger communities. This generation of surgeons must be carefully trained in our hospitals under experienced supervision. Only in recent years have any of our hospitals, even the large teaching institutions in Boston, given sufficient training to qualify their graduates to do surgery in their own right. This is now being well done in many of our larger teaching hospitals throughout the country, but more opportunities are needed for young men anxious to give time and effort for a sound surgical training. The development of proper staff organization in the larger general hospitals of this Commonwealth not only will offer more opportunities for a new generation of surgeons but also will assure the patients in those hospitals of the high quality of professional care that goes with a resident program.

Organization of the hospital staff into the several specialties, each headed by a man certificated by the specialty board, interested in and willing to give enough of his time and effort to the development of his department, restriction of staff members to those limiting their work to their own specialty and the establishment of a merit system whereby appointments to and promotion of the staff are made on a basis of ability and application rather than seniority are the first steps in assuring professional care of the highest possible quality and to the later introduction of a resident program. I should add that, at least for the present, I consider it neither necessary nor desirable for a hospital to require that all its staff members be either certificated by their specialty boards or that those on the surgical staff be fellows of the American College of Surgeons. Insistence on these credentials will not in itself assure good care and is certain to prove a hardship to many able men who by years of application are capable of and are doing excellent work in their communities. Ability, application and a progressive and active interest in the continued development of the medical-care program rather than diplomas on the wall should be the basis for appointment to the staff of our community hospitals. I do believe, however, that all heads of departments and men holding senior staff positions should be certificated by their boards and that the surgeons in more responsible positions should be fellows of the American College of Surgeons.

Any staff organization that does not recognize and include the general practitioners of the community that the hospital serves is not giving full service to that community. There are those who have said that the days of the general practitioner are gone, but the general practitioner has been, is now and will continue to be the real backbone of our medical-care program. The American Medical Association has recognized this in the establishment of a Section of General Practice, and it is probably only a matter of a short time before there will be a specialty board to certificate men in general practice as well as men in the various specialties. They are an intimate part of medical care in any community and must therefore be an active part of the staff organization of all except the highly specialized or the large teaching hospitals.

Closely associated with the staff organization is the development of a teaching program without which no hospital staff can continue to fulfill its complete obligations to the community. Teaching at

some level is possible in every well organized institution. Teaching will be most effectively done and at its best if there are active young minds attached to the hospital as part of a training program. Even without interns or residents, however, hospital clinics, clinicopathological exercises and other scientific programs can and must go on continuously to stimulate the thinking and reading of the staff members and to assure to all patients of the community the benefits of the newer trends in medicine.

What about research? Let us never forget that all medical education and all investigative work have as their ultimate objective the improvement of the medical care of people who need it. Unless new discoveries can find clinical application, they are of little or no importance. One of the really great problems in American medicine lies in the practical application of what we learn to the people of the communities we serve. The possibilities for real constructive advances in the development of medical services in the hospitals of this Commonwealth are almost limitless. That many of even the common medical and surgical cases still come to our larger cities is a natural result of the concentration of the more highly trained internists and surgeons in those areas. As more young men are well trained in the various specialties, however, the trend in medical care for all but the more complicated conditions must be from our larger metropolitan teaching centers back to the communities in which the patients live. The opportunities for men with imagination to develop sound, workable programs in our community hospitals that will make this possible offers a challenge equal to that of the teaching hospital and its laboratories.

Probably one of the most important contributions of good staff organization and co-operation comes from the free exchange of knowledge through frequent use of consultations. These consultations, to be truly effective, must be unrestricted and must make use of any member of the hospital staff, or if necessary of the staff of a neighboring hospital, who can give the greatest help toward the solution of a given patient's problem. In no small degree, the excellence of care given in any one of our hospitals is reflected in the degree to which the consultation service utilizes the knowledge and experience of the entire professional and laboratory staff.

Available to Everyone — Regardless of Race, Color, Creed, Financial Status or Place of Residence — Every Known Essential Preventive, Diagnostic and Curative Medical Service of High Quality.

To make medical care available to all the people of the Commonwealth, 84 per cent of whose net weekly income is below $60, when the cost of a ward or semiprivate bed in a Boston hospital (exclusive of the cost of special nurses and professional care) varies from $80 to $90 a week, is a challenging undertaking. In addition to a mechanism of providing for those who cannot pay for themselves and of obtaining more complete prepayment coverage of the remainder of this group, careful re-evaluation of our present pattern of hospital care should be undertaken so that when economic conditions permit, hospital services may be altered to allow complete coverage to the patient in a ward or semiaccommodation at the lowest possible cost to the hospital and patient, with this cost shared by all patients, whether actual or potential recipients of total service, and paid for through membership in a voluntary prepayment plan. Accomplishment of this goal can be possible only if there is thoughtful, aggressive, co-operative effort of the public, the medical profession, the hospital and nursing authorities, our voluntary medical and hospital services, our charitable agencies and the local and state government units.

To assure continuing improvement of the quality of medical care requires additional effort by and co-operation between hospital governing boards and the professional staff. A well run hospital of adequate size with an effective staff organization, a teaching program and finally the development of resident training will offer to its community a quality of service of which it can be justly proud.

You and I have the good fortune to live at a time and in a state when what should be can be — but only if we as individuals as well as a society offer the active far-sighted leadership and the co-operation with other agencies that are so essential to success.

The attainment of such medical care must necessarily be an evolutionary process which will require the co-operation of all concerned over a period of years.[1]

Addendum. I am indebted to those innumerable and stimulating committee meetings, conferences, personal discussions and communications from which I have learned and to which I owe so much.

References

1. *Basic Principles Which Should Govern Medical-Care Plans.* 7 pp. Massachusetts Medical Society, Feb. 6, 1946.
2. Faxon, N. W. Voluntary hospital — how can it survive in modern world? *New Eng. J. Med.* **236**:460-464, 1947.
3. Mimeographed letter, dated December 10, 1945, to all officers of the Public Health Service (Subject: The National Health Program). From: Thomas Parran, Surgeon General, United States Public Health Service.
4. Getting, Vlado A. Commonwealth's health program. *New Eng. J. Med.* **236**:626-629, 1947.