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### THE MASSACHUSETTS MEDICAL SOCIETY AND THE ORGANIZATION OF PUBLIC-HEALTH SERVICES — RETROSPECT AND PROSPECT\*

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**A**N invitation from this distinguished society to deliver the Annual Discourse is a signal honor — one that I deeply appreciate and of whose significance I am keenly aware. It may or may not be of some moment that I am the first commissioner of public health to be honored in this way, but, in any case, my emphasis here on matters of public health will not be a “first” in the history of this occasion. A large number of the discourses have been on subjects that are clearly within the area of public health or closely related to it. They have ranged in content from such obviously germane topics as the effects of mass programs of immunization to important problems of medical economics. It should be noted, too, that although I am the first commissioner among those who have addressed the Society in this long succession of speakers, there was one, Henry P. Walcott, who occupied a similar role as far back as 1889. He was chairman of the State Board of Health, a position that he held for twenty-eight years, and his topic on that occasion was “State and Preventive Medicine in Massachusetts.”<sup>1</sup>

#### BEGINNINGS — IDEAS AND PEOPLE

While I am in this historical frame of mind, it may be well to look back for a moment and review a few of the events that, with the perspective lent by hindsight, now stand out as important milestones in the evolution of this pact, this partnership in public responsibility that has been shared by government and the Massachusetts Medical Society through the years.

The charter of the Massachusetts Medical Society was granted by the General Court in 1781. It was the first such document to be issued by the new state government, and it reads, in part, as follows:

Health is essentially necessary to the happiness of Society; and its preservation or recovery is closely con-

nected with the knowledge of the animal economy and of the properties and effects of medicines; the benefit of medical institutions formed on liberal principles and encouraged by the patronage of the law is universally acknowledged.

Many years later, in 1924, Stone<sup>2</sup> outlined in his Annual Discourse the purposes for which the Society was founded. They were stated thus:

The advancement of public health.  
The advancement of medical knowledge.  
The sound training of physicians.  
The information of the public upon medical matters.

As though in anticipation of these basic objectives, the Massachusetts Medical Society petitioned the Legislature in 1861 urging the establishment of a state board of health. But this event had been preceded by years of study and effort by responsible persons who were deeply concerned about health conditions in the Commonwealth. One of the leaders in the advancement of public-health measures under law was Dr. Henry Ingersoll Bowditch. Long familiar with the work of Chadwick in England, he was dismayed at the poor sanitary conditions of this country and deeply troubled over the lack of action to remedy them and to control rampant communicable diseases.

It must have been a frustrating and bitter period in the life of Dr. Bowditch. Eleven years before the Society's petition, the report of a legislative commission had laid a solid scientific foundation that clearly supported the need for organized public-health activity. A member of the Legislature, a Boston bookseller named Lemuel Shattuck, had written the memorable document that has become one of the classics of medical literature, but nineteen years elapsed before its recommendations were translated into action.

Shattuck's now famous Sanitary Survey of 1850 may have languished on some official shelf, but it had eloquent spokesmen in the community. The medical profession was, of course, in the forefront of those

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demanding that the State Government take an active role in minimizing conditions that needed attention at mid-century. As time wore on, epidemics — many of them aggravated by the chaotic conditions that grew out of the Civil War — spoke eloquently, too. Diphtheria reached a fearsome peak; the death rate from tuberculosis stood at about 400 per 100,000 of population and accounted for 20 to 25 per cent of all deaths. These pressures from medical men and medical crises accumulated without apparent effect until 1869, when, ironically, the wife of a legislative leader pressed for action. She was prompted by a typhoid epidemic that occurred in a girls' school in which she was personally interested; this final straw broke the back of legislative resistance and brought about the first agency of its kind in this country — the Massachusetts Board of Health.

Dr. Bowditch became the chairman of the Board and was a logical choice for such an important position. His leadership within the medical profession itself, his intense activity in promoting the idea of a state board of health and his keen sense of organization made him especially well fitted to guide the Board in its early years of development.

#### DEVELOPMENTS — THE PARTNERSHIP OF PUBLIC HEALTH AND PRIVATE MEDICINE

It was noted above that the birth of the new Board, attended by a proud medical profession, was not accomplished without considerable travail. Let us now see how the relation between these two entities developed. In order to do so, we may briefly consider two important and well known programs as concrete examples: tuberculosis control and the cancer program.

##### Tuberculosis Control

In a survey of the field of tuberculosis, we come again upon a familiar name, this time that of Dr. Vincent Bowditch, the son of the Board's first chairman. For some years he had sensed the need for an institution in the vicinity of Boston for the benefit of the many persons who, for pecuniary or other reasons, were unable to go to distant health resorts for treatment. As a result of his efforts, Sharon Sanatorium was opened in 1891. It was soon demonstrated that tuberculosis could be cured near home and that bed rest was a more important element in its treatment than the vaunted salubrious climates of distant health resorts. As a direct outgrowth of this work at Sharon, the State appointed a board to select a site and to build thereon a hospital for consumptive patients. Thus, in 1898, the first state-operated sanatorium in this country was opened at Rutland, Massachusetts.

With the acceptance of the idea that tuberculosis could be cured and with the establishment of a means of doing it, medicine could now turn its attention to

the tasks of prevention and improved control. In 1907 the Legislature caused fifteen health districts to be created, administered by physicians working on a part-time basis and known officially as state inspectors of health. Each was charged with the responsibility of informing himself on the prevalence of tuberculosis and other health hazards in his district.

In 1914 the Metropolitan Life Insurance Company showed the practicability of community effort to control tuberculosis — the Framingham demonstration. In a seven-year period this program reduced the tuberculosis death rate of that community from 121 to 38 per 100,000 population. This was followed in 1916 by the enactment of a law making it mandatory for the counties to erect and maintain hospitals with sufficient beds to care for the tuberculous patients of each county. And in 1924 the ten-year program of Chadwick Clinics was started as an intensive effort to discover, treat and eradicate tuberculosis in children. Thus was the pressure against this disease maintained over the years.

But although the tuberculosis programs that have been developed over the last seventy-five years owe their success to a high degree of co-operation between government and the medical profession, the present-day harmony was not achieved without the intrusion of painful periods of dispute and contention. There was reluctance to support the spending of tax funds for the long-term care of consumptive patients; considerable suspicion and misgivings were aroused when physicians were appointed as district health officers, since it was feared by some that they might interfere with the clinician's treatment of his patient. Even the provision of laboratory services for the identification of tubercle bacilli was not viewed as an unmixed blessing. Undoubtedly, the most controversial aspect of the new plan was the compulsory reporting of tuberculous persons by name to the Board of Health. It was strenuously resisted by the medical profession as an unwarranted invasion of the patient-physician relationship.

At this juncture, it is well to point out that opposition to these measures was not universal in the medical profession. Some of its members opposed, but progress came about through the vision and leadership of others, and because of their vision we have been able to move ahead to the present situation. Today, we have many more sanatorium beds than there are patients to fill them, and the virtual eradication of this once great killer is close at hand. The fact that this progress has created a problem in the teaching of medical students is disquieting, but we would obviously rather contend with this problem than with the disease itself.

So much for tuberculosis. There are those who, in discussing the role of health departments, contend that tuberculosis control is a logical area for governmental activity because the disease is communicable and requires community surveillance. But what of

cancer? Here is a noncommunicable disease that, unlike tuberculosis, has been on the increase for the past fifty years.

### The Cancer Program

The need for government to concern itself with the problem of cancer control was noted by the Board before the turn of this century. It is instructive to study the interaction between organized medicine and government in the development of *this* type of program, in which the factor of contagiousness does not operate but where, nevertheless, the task is that of coping with a problem whose magnitude is increasing.

In 1900, in the thirty-second annual report of the State Board of Health, W. F. Whitney<sup>3</sup> presented a painstaking review of the statistics on cancer mortality. A year later, he delivered the Shattuck Lecture before the Massachusetts Medical Society and on this occasion again showed a keen awareness of the growing importance of cancer as a health problem.

In 1916 the Massachusetts Medical Society appointed a cancer committee with Edward Reynolds as its chairman.<sup>4</sup> In its very first report this committee recommended state-wide opportunities for free laboratory diagnosis of pathologic tissues, and it also urged a widespread campaign of public education. The committee was responsible for other advances, such as arranging with the various district societies to devote one meeting a year to the subject of cancer control, and the initiating of Cancer Week in 1921.

Others were active, too. In 1917 the Harvard Cancer Commission volunteered to diagnose specimens of tissue suspected of being malignant. The connection between the recommendation by the Society's Cancer Committee of this as a needed service and the offer made by the Harvard Cancer Commission is readily apparent. The next logical step followed promptly: in 1919, Dr. Eugene Kelley, Commissioner of Public Health, requested funds to assist in the support of the Tumor Diagnostic Service and to conduct an educational campaign. The diagnostic service has continued to be a joint effort of the Cancer Commission and the State up to the present time.

In 1914, after his attendance at the International Cancer Conference in Brussels, Dr. Francis D. Donoghue introduced a resolve in the House of Representatives to study the general problem, but the Legislature did not authorize such a study until 1925, when the departments of Health and of Welfare were directed to study the problem jointly and submit a report. The outcome of this work was that in 1926 the present cancer clinic program was authorized, as was the transfer of Pondville Hospital from the Department of Mental Health to the Department of Public Health and its designation as a facility for the treatment of cancer.

Although the Massachusetts Medical Society provided much of the impetus for the development of

the cancer program, it furnished strong opposition — at the time — to the operation of a cancer hospital by the State; nor should it pass unmentioned that the Health Department itself was far from enthusiastic about the idea! Curiously enough, support for this move came from the laity. Prominent among the leaders were Monsignor Ambrose F. Roche, of Watertown, Mr. Wilbur Trussell, one of the founders of the Massachusetts Society for the Control of Cancer, and State Senator (now Congressman) John W. McCormack.

Pondville Hospital was opened as a cancer hospital in 1926 and has served its purpose admirably, not only in the realm of treatment but in the functions of research and the specialized training of physicians as well. A section of the statute that established the cancer program calls attention to the Legislature's determination to defy the attitude of organized medicine. It reads:

The department, with or without the cooperation of local Boards of Health, hospitals, dispensaries or other agencies shall establish and maintain cancer clinics and may otherwise provide services and treatment for cancer.

Whereas a detailed evaluation of the cancer program is not within the scope or intent of this discourse, it may at least be noted that results have measured up to our hopes and expectations. The tumor diagnostic work has provided an excellent resource for practicing physicians and has encouraged them to have suspected tissues examined. The cancer clinics are available throughout the State and are providing excellent services for diagnosis and follow-up study. The hospitals give expert care and cooperate fully with the medical profession and with other hospitals in the use of expensive equipment, as well as in the performance of highly technical surgical procedures. A large number of physicians in the Commonwealth have received training in the management of this disease at the hospitals operated by the Department. And, lastly, important contributions have been made to our knowledge of this problem by the various aspects of the research effort.

Here, then, is a venture in public service that has endured as an activity of the Department of Public Health for more than forty years and has earned favorable acceptance and support from the medical profession. Apart from the curious fact that there are still some physicians who regard the cancer program as an autonomous entity operating outside the orbit of the State's public-health work, it is nevertheless gratifying to have periodic assurance from the profession at large that this undertaking is an appropriate activity for state government and that it is being adequately managed. The old question of the extent to which the cancer program has interfered with private practice is rarely raised these days. Moreover, so far as the Legislature is an index of public attitudes, there is consistently strong support for the Department's

cancer-control activities; the program is clearly accepted as one of the modern responsibilities of government.

Laying all speculation aside, one may postulate that this high degree of approval results from the fact that the cancer program evolved from a pressing need whose true dimensions were accurately assessed by those concerned, and that it was developed in close collaboration with the medical profession. In this connection, full recognition must be given to the contributions made by Drs. Eugene R. Kelley, George H. Bigelow and Herbert L. Lombard. Their zeal in laying a sound foundation and their tireless efforts to obtain the understanding and support of organized medicine were crucial ingredients in building the program to its present stature.

### NEW AREAS FOR JOINT PLANNING

And now, a new problem looms before the people of the nation and has found its way into the debates of the public forum — one that is not concerned specifically with disease as such, either communicable or noncommunicable. This is the challenging problem of medical care for the aged. For reasons well understood by this assemblage, we are witnessing an era in which our increasing population is living longer and contains a greater proportion of old people than ever before. We know that this is not a transient situation and that the weight of its implications will increase before the statistical picture becomes relatively stable. Whatever economic and political debates may rage, this is a responsibility that civilized society must assume. That both medicine and government should participate is scarcely debatable; the question is merely one of how rather than whether.

The Great Depression of the 1930's taught us that voluntary welfare organizations were not adequate to bear the burdens imposed by national crises. The massive and rapid growth of our economy has brought about changes that have far-reaching consequences, and, irrespective of differing political philosophies, there is nearly universal agreement on the propriety of government extending its functions and resources to embrace areas of community life in a way never imagined by our forefathers when this nation was born.

#### Government and Community Health

Properly or not, the State has been in the business of health up to the hilt and could not extricate itself even if it were sensible to do so. Government has no desire to assume undue proprietorships, but it will take the best minds and talents we can mobilize if we are to match the vision and discrimination of those who have preceded us in making a viable blueprint for the future — a plan that will confine governmental activity within limits that will best serve the public interest and, at the same time, enhance the rights and

basic incentives of the medical profession. This is not to say that walls should be built around separate domains; it is to say that the health department and organized medicine should supplement one another, sometimes through co-ordinated efforts in disparate fields, sometimes combining for the sake of maximum accomplishment in the same field. But none of these things can be fully realized without the clarifications and easy communication that are the by-products of joint planning; no enduring philosophy can emerge to guide us through the difficult years that surely lie ahead without complete co-operation.

Whatever the future is to bring in terms of planning requires an inventory of the Department's present activity and a statement of what it sees as some of its problems. The trend toward a broadened responsibility in the realm of chronic disease is clear. The Department did not start operating hospitals until 1920, when 4 state institutions were brought into the structure as part of the Division of Sanatoria and Tuberculosis Control. At the present time, the Department has 390 beds for tuberculosis, 160 for cancer, 360 for crippling conditions and 2284 in the general category of chronic disease. The operation of these institutions accounts for 75 per cent of the Department's budget.

Another function that grows naturally out of our responsibility for actually providing care is the licensing of hospitals, nursing homes and rest homes. This program was developed with the active co-operation of the medical profession and those concerned with the operation of hospitals and nursing homes; it has been designated as a necessary function of government and has placed an important task in the hands of the Department, that of establishing minimum standards for physical facilities and the qualifications of personnel. Still another adjunct of the Department's activity is our responsibility for the allocation of funds that are available for hospital construction under the provisions of the federal Hill-Burton Act. Although functions of this sort are not medical in the literal sense, they are not without influence in shaping the character of the medical-care program of the Commonwealth.

#### Chronic Disease and Community Resources

However, our program must not be allowed to become arrested at its present level of development. There are many problems that urgently require solution. A case in point is seen in the difficulties associated with the provision of continuing care of good quality in the management of chronic disease. Our hospitals are like islands of efficiency surrounded by areas that do not contain the rich variety of facilities necessary for the support of the physician's treatment goals. Far too often, the patient who could be at home must remain in the hospital or be returned to a community setting that is poorly organized in terms

of its medical care. Thus, a reasonable and attainable aim for the concerted efforts of government and organized medicine is that of developing services in the community to a degree of reliability that will approximate the excellence of service to be found inside our hospitals.

It may be that the term “medical care” is too general for the direct communication of what I intend as a specific suggestion. If we refract the phrase, so to speak, into a five-part spectrum, it is possible to see its components — namely, health maintenance, office treatment, care in the home, hospital care and custodial care. In the same manner in which these categories range from the well patient to the chronically ill or disabled, there is a progression from the least to the most expensive forms of medical care. Herein lies the key to planning and action on a broad scale. It involves the co-ordinated use of voluntary and other agencies as resources for the practicing physician to avoid duplication of effort on the one hand and to improve health services for our citizenry on the other. It would attempt to shift the emphasis from the hospital-type services that are often most expensive to services that are preventive and much less costly both in financial terms and to the welfare of the patient.

Major obstacles stand in the way of a more effective public-health service, and they affect a field of action even broader in scope than that of chronic disease alone. These obstacles are derivatives of and, in large part, attributable to weaknesses in the structural aspect of the state’s local health services. For example, of the 351 communities in the Commonwealth, there are 144 where boards of selectmen discharge the responsibilities of a board of health in addition to their normal duties. This means that in 43 per cent of the state’s communities there is no single organization *primarily* concerned with the health problems of its citizens. This fact would be less disturbing if one could feel that, in general, physicians participated actively in the formulation of the health policies of their local communities, but, contrary to popular belief, they do not. There are 189 additional communities where boards of health *do* exist, but in all 333 of these two groups of communities combined there are fewer than 40 per cent that have the benefit of medically trained personnel to participate in their deliberations and activities.

The fact that the Department of Public Health is not equipped to be of optimal assistance to the areas most lacking in resources only adds to the frustration of all concerned. At present, the entire state is divided into 5 geographic areas served by only 4 district health officers, who, in each case, act in advisory and “trouble-shooting” capacities to a large number of localities. The two western districts, covered by 1 medical officer, comprise 100 communities, 670,000 persons and 2800 square miles; the Northeastern Dis-

trict embraces an area of 838 square miles and 65 communities with an aggregate population of well over 1,500,000. The remaining 2 districts are no better off with regard to adequate coverage. Contacts between a given local health agency and the district health officer are, perforce, infrequent and of minimal impact except in cases of emergency. A mere courtesy visit once a year to each community would consume about half the working time of any district officer.

To sum up, the inescapable fact is that, although a few communities possess well organized health departments, the ability of boards of health and of selectmen to deal with the health problems of their people falls seriously short of attainable standards. This statement is made in sympathy, not in criticism. Most of those involved are hard pressed, conscientious officers who are well aware of the disparity between the size of their tasks and the tools available for accomplishing them. I have met with representatives of these boards personally and believe that I am giving voice to their points of view. They want help and guidance; the Department wants to join them in finding practical answers to their most elusive questions.

#### SOLUTIONS AND PROPOSALS

To find solutions to these pressing problems, it is necessary to develop a set of guiding principles that can be applied to the wide range of situations in which we continually find ourselves. If it is true that we have too frequently insisted that functions must adjust themselves to a predetermined structure, it follows that our search must be for an operational framework that is capable of bending itself to the tasks that must be performed. Not long ago, I was told a story about a college that was established in this country. In planning the sidewalks from one building to another, the architects decided to wait and see where people actually walked before laying out the pathways and pouring concrete. When the school was opened and students began to move about the grounds, natural paths were formed, sometimes cutting diagonally across grassy areas, sometimes describing arcs and angles — depending on the kind of needs and habits that developed. Permanent walks were then made to follow these paths and, so the story goes, the newly planted grass was allowed to grow without warning signs or roped-off areas — which often do not work anyway.

Our problem is more important than the nurture and development of thick carpets of grass, but I believe that a principle in this story is applicable to the over-all problem of devising local health services that will be performed in a well co-ordinated and effective manner. The solution, of course, lies in understanding the ways and habits of our people, both lay and professional, and the logistics involved in serving

their needs with the resources at hand. From this point of view, geographic boundaries serve no constructive purposes unless they facilitate the development of sound functional relations.

What, then, are the alternatives? What pathways can be followed that will lead us to increased communication without endangering valuable, indigenous social structures? How shall we establish two-way traffic between medicine, government and the people without treading on somebody's cherished grass?

#### Planning at the District Level

My most recent reflections have led me to take a hard look at the organizational structure of the Massachusetts Medical Society and its 20 component districts. As one examines the geographic distribution of these districts, it becomes obvious that they correspond quite closely to what may be called "trade areas," or medical-service areas. In so doing, they fulfill a prime requisite for the efficient reorganization of public-health services by and for groups who have both manifest and implied commitments to each other within contexts of social interaction that tend to foster communication rather than to impede it. In the face of our acknowledged need for closer collaboration, it may be most logical to revamp the Department's mechanisms for local health administration along lines that will correspond with the Society's district pattern. Besides satisfying an important principle of organization, such an arrangement would provide opportunities for local health boards to work closely with organized medicine in a way that is only fortuitously possible under present circumstances.

Public-health activities have a desperate need for the insights and leadership of the medical profession throughout our network of local communities. It is not enough that, traditionally, there has been a high degree of co-operation between the Society and the Department at the state level, where relatively few persons from each group are involved; the active participation of practicing physicians in the communities is needed. It is vital for them to exercise leadership wherever they are, because unless they become the heart and soul of the broad public-health function, this service cannot become a mature enterprise with the wisdoms necessary for meeting the challenges that are to come — to say nothing of those that are already upon us.

We in the Department of Public Health are convinced that there is a way of working with the medical profession at the district-society level so as to bring about desired results and with the full co-operation of local boards of health. To this end, we intend to approach one or more district societies soon to elicit their help in working out a plan of study that will enable us to demonstrate whether our considered opinions have validity in the field of practice. We need to know whether public-health organization at

the local level is amenable to changes that may be indicated by whatever pertinent facts are brought to light, but most of all we want to preserve what is best in the principle of local mobilization for the solution of local problems. It is our hope that the rank-and-file members of the Society will reassert the leadership in local health affairs that is rightfully theirs. Their voices are needed. If these roles are not filled by medical men, they will be taken over increasingly by others less well qualified. Actually, a large intrusion into community health programs has already occurred: school boards were the first to organize school health services in a number of localities, and there are medical-care services operating with large budgets in the State departments of Education and Welfare. The Department of Education developed the physical rehabilitation program, and the Department of Welfare has expanded its medical-care section to a point where it is now the largest single program operated by this state agency. This fact has serious implications. Health programs are scattered through many parts of state government and often have little or no dynamic contact with the medical profession. It is not that there is a failure to employ physicians to do medical chores; the point of my complaint is that these men are much too remote from the planning and development aspects of these programs. Doctors contribute their technical skills once it has been determined what the activities shall be, but they play a negligible part in designing them. These are structures built without architects. If they are sometimes unlovely in shape, the reasons are clear.

#### Physicians and Community Leadership

Reluctance on the part of the individual physician to assume leadership in community-health affairs is puzzling. It is a phenomenon that is too complex to be explained by a simple statement of causation. There is a myth that physicians are not good administrators, but this is a libel that falls of its own weight. Similarly, it is not possible to give serious thought to the assertion that they are indifferent to community problems. Doctors give freely to the needy; undoubtedly, medicine is still the most generous of the professions, and service to others is so ingrained in their experience that they seldom think of it except as a normal way of life. Nevertheless, the image of the physician as a community leader, especially in the field of public health, is fading. One suspects that the public is being re-educated — through what it does *not* perceive — to associate leadership in local health programs with those who are more vocal and more readily drawn into the vacuums created by the withdrawal of medical skills from the public-health scene. There are no villains in this piece, and no maligning of motives. One simply reports what has happened and registers uneasiness lest it continue. The nonmedical administrator of public health did

not spring full grown out of nowhere; he came into being as a result of needs that could not be asked to wait.

#### Attitude toward Public Health

Still another charge is leveled at private practitioners to explain their apparent aloofness from public-health activities: it is said that they have a serious mistrust of public-health operations as well as of public-health physicians. These criticisms originate from within our own profession and are perhaps epitomized by a statement made by Dr. Ben Freedman in the *Journal of the Louisiana State Medical Society*,<sup>5</sup> from which I quote:

Organized medicine has developed an almost obsessed suspicion of community organized health programs, particularly when administered by the government. Because public health agencies are the traditional operators of community organization health programs, public health physicians, who are agents of the government, have received the brunt of the private practitioner's suspicions and have been tolerated with reluctance in organized medicine's circles.

Closer to home, in discussing the merits of a home care program, a recent president of this society said to me, "You have to realize that you are tarred with the brush of public health."

In spite of the fact that organized medicine gave life to the public-health movement and in spite of the evidence that there has been no demonstrable interference with private practice, a wide gulf continues to separate these two great entities from one another except for the slender bridges that communicate with limited areas on either side. The division is the more baffling because there is no fundamental barrier to their active partnership. Certainly, nobody would seek the discontinuance of public-health activity at this late date. It is all too clear that such programs as tuberculosis control, cancer, child-health services, crippled children's clinics, alcoholism and the investigation of epidemics and of venereal-disease contacts are supportive and indispensable to the private practice of medicine. Nobody would deny that this activity has contributed importantly to the high level of health enjoyed by our citizens.

#### A Positive Program

Finally, it is less constructive to view with alarm than to join forces to solve the problems that exist. Public health and organized medicine have a common heritage and are motivated by the same ethics. These are invaluable assets with which to make a beginning. Realignment of similar nature have been accomplished elsewhere in the face of much initial pessimism. In recent years the Pennsylvania Medical Society has achieved a remarkable resurgence of medical leadership in the public-health field. Through its Commission on Public Health and Preventive Medicine it has revitalized the public-health service of that commonwealth. The physicians of the

state have combined to foster a broad program of public health for each community. The Society is developing a program to encourage gifted young physicians to go into public health as a dignified and rewarding career. At the same time the Society has interested itself in the immediate problem of placing highly competent career personnel in the top administrative posts of the state health department. An active educational campaign, aimed at the establishment of full-time, medically directed *local* health departments, was carried on with remarkable success. At present, the Pennsylvania Medical Society is addressing itself to the problem of fragmentation of health services and their distribution among many state agencies. The goal in this campaign is to combine all these services under the direction of a single agency — one that will be in tune with the aspirations of the communities served and structured according to the ideals of the medical profession. All this is reminiscent of the Massachusetts Medical Society of an earlier day when the activities of the new state board of health were being acclaimed by the groups of physicians who had brought it into being. I submit that it can be so again — that history can repeat itself on the grand scale and in keeping with the multiple requirements of the modern era.

We in Massachusetts have a past that is replete with pioneering efforts in behalf of the public's state of health; the aggressive curiosity, the spirit of adventure that lay behind those heroic achievements has, in some way, become diluted — for reasons that have as much to do with technologic advances as with shifting emphases in the responsibilities allocated to and assumed by government. Furthermore, whereas governmental expansion in the field of medical care is viewed by some as undue encroachment on professional preserves, it has been a long time since the interested parties have convened for the purpose of assessing needs and meeting them with programs that are efficient and technically sound.

I should like to close with an assertion and a plea. All of us recognize the inseparability of private medicine and the enterprise known as the field of public health. This relationship will not change in the foreseeable future. In addition, in the task of fashioning a totality of health care, no individual need bear a heavy burden. It is vital for all to give a little so that a few do not have to give too much. We in public health need your help; the people of the Commonwealth need both of us functioning at our best.

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