Editorials

Medical Associations and the Pace of Change

AN INCREASING PACE of technologic and social change is a dominant characteristic of these times. It affects every aspect of society and each is seeking ways to cope. Medical associations are by no means exempt from the stresses this produces and the need to adapt to them. The root cause of all this, of course, is the scientific and technologic progress that is occurring so rapidly in both medicine and society. And the rate of this progress and the pace of this change is not likely to diminish very much in the foreseeable future.

Medical associations are creatures of their member physicians, and must therefore be responsive to their concerns. But they are also human institutions with a life of their own. They each have an internal and an external environment with which they must interact. The internal environment is made up of all the persons who make up the association or who work for it, and their concerns. The external environment is the external world of evolving patient care and social change affecting medicine and its practice, and the public's expectations of the medical profession. The structural organization of medical associations stems from quieter times when the problems of medicine and the society it serves were less complicated and less intertwined with one another. The intrusion, intervention or participation of third parties in medical practice and patient care had not yet occurred to any significant extent and medical associations were able to devote themselves to promoting scientific medicine, professional education and the public health. But now this organizational structure, which worked so well for so long, finds itself hard pressed to cope with the pace of social as well as professional change.

Medical associations are organized as democratic societies governed by their members who individually have a greater or lesser interest in contributing to or participating in this governance. The governance is left to a relative few. Partly for this reason it is the nature of democratic societies to tend to be more sensitive to their internal organizational imperatives than to what may be perceived by many to be the more important imperatives imposed by the external environment. They also tend to be more reactive than proactive. It is often difficult for them to think or plan very far ahead—that is, beyond the next election. It is also in the nature of any association of humans to develop an internal organization or bureaucracy to enable those who work within the association, who are necessarily dependent on one another, to work effectively together. This occurs whether in the federal government, a business corporation or a medical society. Elected or appointed officials become as much a part of these corporate or societal internal organizations as do the hired hands. And, as this internal organization or bureaucracy takes on a life of its own, it develops its own imperatives and also begins to consume organizational resources that tend to be drawn away from the at least equally important organizational goals that are the stated purposes of the organization. To the extent an organization or association becomes absorbed in itself and unduly focused on its internal imperatives, it can lose its ability to effectively pursue the goals in the external environment which are its reason for existence. Since they are always limited, an association's energy and resources must be skillfully deployed if the organization is ever to accomplish its purposes and goals.

It also should be obvious that if an association is to be effective, it is essential that its purposes and goals be clear, within its professional competence to accomplish, and achievable within its resources. One can only wonder how effectively the always limited resources of some of our medical associations are now being used. To what extent are the internal imperatives, important as they always are, drawing energy and resources away from the external imperatives of the association in the world of medical practice and patient care that is changing so rapidly? And to what extent are the external purposes and goals really clearly defined, truly within the competence of the medical profession to accomplish and actually achievable within the resources of the association? One senses that too often medical associations are attempting to achieve goals that are beyond any professional competence they can bring to bear or what resources they have available. Where this is the case it can only amount to an expensive exercise in futility. And one also senses that the natural tendency of any bureaucracy to focus primarily on its internal imperatives may too often be impairing the effectiveness of some medical associations as they attempt to influence the external environment of medical practice and patient care. To the extent any of this is the fact, a review of an association's purposes and specific goals in terms of its internal and external imperatives, and the professional competence and resources it can bring to bear, would seem to be in order. The pace of change in both medicine and society is now so great that the energies and resources of our medical associations must be applied as efficiently and as flexibly as possible to keep up with an ever increasing pace of change, or organizational failure with all of its consequences may be inevitable.

MSMW

Heterogeneity in Type II Diabetes

ROSALYN YALOW and the late Solomon Berson developed the first accurate and reproducible immunoassay for insulin at the Veterans Administration Hospital in the Bronx in the late 1950s.[1] Thus the initial diabetic subjects who were studied had the non-insulin-dependent (type II) or maturity-onset variety of diabetes mellitus, meaning usually normal or high levels of insulin but yet levels that were disproportionately low relative to the concentration of glucose. In the succeeding 2½ decades innumerable papers have appeared discussing this apparent hyperinsulinemia in persons with type II diabetes and Davidson has reviewed many of these studies in this issue of the journal. The observation that increased levels of insulin are required in many middle-aged diabetic persons, however, goes back much further than the early 1960s; soon