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SOCIAL USES OF MEDICINE

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Seventy percent of our people need medical or dental treatment, but go without because of lack of proper medical organization. Dr. Armstrong is not merely critical, but is constructive. He shows the absurdity of making physicians dependent on sickness for support, and outlines a plan of community procedure on a rational basis.

IN the practice of medicine today is found much that is admirable from the point of view of personal service and community welfare. Ingrained in the system of private medical practice is also much that is chaotic and wasteful, much that is destructive of the best interests of society. Side by side with the glorious spirit of individual self-sacrifice, characteristic of medicine throughout the ages, students of social organization are increasingly conscious today of elements tending toward the perpetuation of inadequacies in disease control, serious qualitative and quantitative deficiencies in diagnosis and treatment, resulting in an inevitable loss to society in preventive and therapeutic potentialities unutilized, and retarding the development of scientific medical knowledge, as well as the elevation and standardization of practical medical service.

ACCOMPLISHMENTS OF MEDICINE

Yet marvelous has been the progress of medicine in the last few decades. Great have been the benefits to mankind resulting from unselfish effort and untiring struggle against the captains of disease and death. Many are the trophies of victory won in this fight to lay a firmer physical foundation for economic, social and spiritual evolution. The sanitation of whole countries has made possible the exploitation of the resources of nature. Smallpox robbed of its terrors, yellow fever conquered, typhoid fever reduced to a disease of minor importance in most self-respecting communities—these are a few of the conquests of *preventive* medicine.

Still, the necessary characterization of these accomplishments as preventive, is not wholly encouraging. This is progress in disease prevention, but it is not es-

sentially a reflection of growth in the routine practice of medicine, the diagnosis, treatment and cure of the everyday minor or serious affections. Unfortunately, the same methods responsible for the advances in epidemiology are not applicable to the control of many of the remaining scourges affecting society. Dependent upon still undeveloped methods is the ultimate control of such major factors in our present mortality as tuberculosis, cancer, kidney and heart disease, probably the less specific respiratory affections, venereal disease, etc.

These advances in disease prevention are in fact a direct measure of organization in medicine. They are the result of organized research, of the social organization of medicine through health departments, sanitary commissions, or similar social devices. The type of medical social organization devised to meet these problems has accomplished part of its task admirably. It still has other fields to conquer. Yet without further and different development in the organized social group use of other existing resources and methods for disease control, we cannot hope for substantial progress in many vital fields. As Sir James Mackenzie has put it, in his recent volume on *The Future of Medicine:* "The next step is to recognize, that if progress cannot be carried further with our present conceptions and methods, we must look out for a new concept, as well as new methods."

INADEQUACIES OF MEDICAL PRACTICE

What is the situation in many fields of medicine today? Investigation shows that 70% or more of any typical population group is in need of medical or dental advice or treatment, for minor or serious ills. How many are ever brought into contact with corrective medical advice? How many are advised or treated while the affection is in its incipiency? How many, even when brought under medical surveillance, receive competent and thorough-going advice or treatment? In what percentage are the laboratory and other technical "instruments of precision" for diagnosis and treatment, although theoretically available for all, actually applied? Why do many physicians everywhere, in spite of state provision, still make or fail to make diagnoses of diphtheria without throat cultures, or syphilis without a Wassermann?

Recent surveys have shown that there exists in normal communities three times as much active tuberculosis as is usually under observation. Why is it that in most communities 20% of the tuberculosis cases first come to the knowledge of the health authorities when reported at death? How infinitesimal is the percentage of surgically curable cancer that is detected in time? What health officer is bold enough to claim that even a substantial proportion of the venereal disease in his community is receiving adequate medical treatment? How many adults or children in the typical urban population ever receive an annual medical inspection—admittedly essential to the detection of early disease and the promotion of hygienic living?

The present method of unorganized private medical practice, devoted and conscientious as are the rank and file of the profession striving *individually* to meet these problems, has been tried and found wanting. Real progress in all allied fields has been concomitant with some degree at least of social organization. Can private practice, through socialization, be converted into a far more effective social instrument?

We all know that the individual in the system is not responsible for this seemingly hopeless and chaotic condition. He is a victim, with those he is seeking to serve, rather than a promoter of the system. The status of medicine today is one of the many symptoms of the semi-anarchistic, individualistic organization of social life. It shares with other phases of the unsocialized state the glaring imperfections of society. Syn-

thetic-minded leaders in all walks are seeking an adequate program. Indeed, this is conspicuously true in medicine. Unfortunately, here as elsewhere, progress or even the experimentation essentially prerequisite to progress, must be made against the lethargic opposition of many who lack the spacious-mindedness necessary to grasp the significance of the present acute problems of this war-altered world. The problem of utilizing social forces for the physical betterment of man presents many inherent difficulties. Change there must be. Shall that change be radically disruptive or conservatively constructive?

NEED FOR SOCIALIZATION

As some one has put it, "the whole world is yeasty." Changes are inevitable, changes involving new relations, new social adjustments, new usages for social organization. Now, is it not true that past history shows a tendency toward the development of new social instruments? Certainly this is true of medical history in particular. The great modern advances in disease control, barring a few unpremeditated, unplanned, accidental discoveries by isolated individuals, have been the result of organization, either for laboratory research, field study, or other experimentation. Shall we not therefore find, that in order to solve the major difficulties of medical practice today, we shall have to have a further socialized organization of the forces now wasted or imperfectly used?

Certainly no doubt can remain as to the inadequacy of the present day arrangement, particularly on the side of case treatment. Speaking with international authority Sir Arthur Newsholme says:

"That the work done on behalf of the community, *plus* the work accomplished by private medical practitioners, is not equal to national needs, is obvious to anyone considering the vast amount of avoidable disease in our midst. Why is this and what is the remedy? . . . The medical provision made in a large proportion of cases is belated and inadequate; it commonly does not include the full resources of medicine; and in perhaps a still larger proportion of cases medical advice is not obtained, or being obtained is not followed. This applies even more to hygienic than to clinical medical advice."

In the face of these difficulties there are those in the medical ranks who would urge that the physician be concerned only with clinical medicine, only with the treatment of individual cases, leaving disease prevention, and the promotion of hygiene and allied problems, entirely to the sanitarian and the social worker. The weakness of this must, however, be apparent to anyone seeing the problem as a whole. It is one problem, a problem of social medicine—a movement that must push forward in a united advance on the bulwarks of disease. We cannot separate the treatment from the prevention of disease without jeopardizing the success of both.

SOCIALIZATION TO DATE

At what preliminary conclusions have we therefore arrived? Is not the answer the "socialization of medicine"? Why is this phrase to the average medical man "like a red flag to the Attorney General"? Is the socialization of medicine something new and unheard of? Have we none of it to date? Is it something terrible that is going to befall us over night? Are we being led astray by fools captured by catch-words?

On the contrary, the socialization of medicine began with the earliest clinic, hospital or health department; and has slowly and inevitably broadened in scope and increased in momentum, to the inestimable benefit of the public and of the medical profession itself.

Indeed, the social tendencies in medicine today are following many sound precedents. There was a time, for instance, when most communities got their water supply from individual wells.

Then there came a time when a common (social) water supply was found to be safer, cheaper, and in every way better. Medical service is now passing from this individualistic stage to the stage of social conservation and social control.

Those who object to the theory of "socialization" do not usually oppose its practice. Consider such universally accepted examples as the following:

1. The development of a medical cooperative group method of treating disease—namely the hospital public ward.

2. The establishment of diagnostic and treatment facilities for large social groups, medical equipment and personnel being employed in common—namely, the clinic or dispensary, and all out-patient service.

3. Community health organization, official and private health bodies—representing the interests of the whole community as to disease prevention and control.

4. The employment of medical service for large population groups in society, as for the school children, the industrial workers, etc.

5. The development of group practice and specialty clinics, rendering available diagnostic and treatment facilities otherwise beyond the reach of the average physician and patient as well.

6. The fostering of routine medical examination and advisory work for large unorganized groups of individuals by the employment of organized medical forces, such as through the Life Extension Institute, and other agencies.

7. The preparation of vaccines, sera, etc., by the state, for social use.

8. Finally, and perhaps most significant thus far, the employment of *organized medical* forces, in the development of general *social machinery* for the prevention and treatment of disease and disability, as in accident and sickness insurance, imperfect as is our social organization in these fields at present, inadequate and unsatisfactory as has been the practical provision on the medical side.

Are not these measures more than "a tendency toward the socialization of medicine"? What, in fact, is the "socialization of medicine"?

Before reaching a definition of this term, let us say once and for all that this is not an attempt at the analysis of detailed method in the present medical system. It is more an effort to interpret the existing spirit and doctrine of medical service and disease control. Neither is it the plan to outline and discuss specific recommendations, such as health insurance, for instance. Rather, it is hoped to indicate certain broad lines delimiting the range and direction of future progress. Our interests are not in the theories but in the practical program. Our argument is not for "the type of mind that would rather play with a perfect theory than improve an imperfect world."

WHAT IS SOCIALIZATION?

What does the socialization of medicine mean? Does it not mean the use of medical knowledge and facilities for constructive social ends? This implies the social attitude, namely, the attitude of service.

Now, from this point of view, there are few who will not agree that the practice of medicine, in spirit and motive, is the most socialized instrument for physical betterment at work in the world today. The physician has the spirit of service. He succeeds to the extent to which, through his unorganized individual efforts, he is bettering the lives of others. He possesses the social attitude; his social defects are therefore largely those of method and organization. All that is implied by the term is admirably expressed by Sir Arthur Newsholme:

"The definition of the sense in which I employ the term socialization in medicine—would include the rendering available for every member of the community, irrespective of any necessary re-

lation to the ordinary conditions of individual payment, of all the potentialities of preventive and curative medicine."

IMPENDING SOCIAL DEVELOPMENTS

We need not be concerned over the spirit of service essential to this object. It is there and always has been. How can medical facilities be organized practically, for the attainment of this end? That is the great problem, upon the solution of which real progress in further disease elimination depends. Still, do not all the current manifestations of socialization previously discussed bring us several steps further in the direction of the goal? Are we not on the verge of fresh developments in this same direction? What, in fact, are the impending developments in the social life of medicine through which we may hope to see the methods of medical practice more nearly approximate the admirable social spirit which inspires the medical world? Perhaps a few of these "next steps" may be indicated as follows:

1. The further development of public and private health organizations, using their machinery for disease control, for the elimination of non-communicable and degenerative causes of disease and premature death, such as cardiac, nephritic, and other affections, as through dietary education, cardiac classes, etc.

2. The further development of adequate training for medical men in medical schools in the science of disease prevention and early detection, the principles of hygienic living, as well as the treatment and cure of specific cases of disease.

3. Adequate post-graduate instruction, providing a means for continuous, up-to-date contact with the more recent medical discoveries, possibly involving periodic re-examinations on the essentials of diagnosis and treatment—thus strengthening the relation between the State and the physician, with the object of better medical service.

4. The extension of clinic and dispensary medical facilities on a pay basis for wider groups in the population—a further socialized use of the clinic method.

5. A great extension of organized, age-group diagnostic and advisory work, bound to come in the near future, including full-time medical, dental, nursing and clinical personnel and equipment for school children, industrial workers, etc., and providing facilities for routine medical examinations.

6. Organized efforts to provide annual medical examinations for the population at large, through such agencies as the Life Extension Institute, medical examination clubs, national medical examination campaigns, etc.

7. The development under government auspices of expert itinerant advisory and consultant service for the general practitioners on diagnosis and treatment, covering difficult and doubtful cases in many of the specialties such as tuberculosis, infant welfare, internal medicine, etc.

8. Possibly the districting of medical service, at least to meet epidemic emergencies, leading perhaps to the setting up of competitive standards of excellence, graded on a basis of disease prevented and health maintained.

9. The reincarnation of the "old family physician," as the guardian of the family's health and the teacher of family hygiene—the treatment of the family to be carried out on the "keep well" basis, a practice erroneously said to be common in China, but one which shows definite signs of development in this country.

10. The further and more equitable development, as an experiment at least, of accident and sickness insurance, merely an item in the whole program of socialization, but one around which centers most of the storms of discussion at the present time.

HANDICAPS OF PRESENT-DAY PRACTICE

"The physicians are opposed to the socialization of medicine." Any one will tell us that, but is it true? Certainly they do not like the term. Certainly they do not favor health insurance. But that is only one aspect of the tendency so manifest today. Any one who has had any experience with the initiation of practically any of the phases of socialization enumerated above, with one or two exceptions, will testify that the physicians not only are in favor of the measures, but give them full coöperation and hearty support.

In fact, it would be difficult to imagine why the physicians should be opposed, why they should approve the *status quo*. Surely they are not in love with present conditions. The doctor accepts his lot with superior good-will, but he works in the face of almost intolerable obstacles. A few of the disagreeable elements which, to a great degree unnecessarily, burden the life of the general practitioner are:

1. More than any other occupational group the physicians are called upon to meet the demands of long hours, excessive over time, night work, etc.—all, with relatively few exceptions, for a "white wing's" pay.

2. Not only is he under-paid for the services he performs, but the doctor's collections are frequently poor. It is considered poor etiquette to be too "business-like" in insisting upon payment and he faces the subtle public sentiment that rather discredits the man in medicine who "makes money"—a condition that prevails in no other calling.

3. He is required to maintain the morale of the soldier—takes the risks of the soldier—yet there is for him no remuneration while in training, no promotion, no pension, no discharge—a life with the severest duties and with few rights.

4. From him is demanded more volunteer service, without compensation, or recognition, than is the case in any other profession.

5. While he may have been an excellent student in school, an enthusiast for research, a man who had genuine scientific interests, the economic pressure to which he is subjected in practice will not only give him no chance for continued study, but will often dull his sense of scientific values and his enthusiasm for worthy endeavor.

6. If a general practitioner striving to develop a specialty, he has to fight for every minute of time to study. Then, he must face that part of the public that sneers at specialists, and at the same time expects to find for a dollar office call all the specialties combined in one man—a surgeon, an ophthalmologist, a pediatrician, a tuberculosis expert, and what not, never realizing, in the words of the old adage, that "a jack of all trades is master of none."

7. Economic pressure, again, will probably prevent the devotion of his time and interest to the work for which he is best fitted. How many potentially excellent neurologists or research men are wasting their time on routine life insurance examinations, to eke out a living?

8. If he has devoted years to thorough training, he is still likely in some communities to find himself in competition with a graduate of a correspondence school or a night diploma mill.

9. He may start out with high ideals of service, with the desire to keep accurate records, anxious to meet his full obligations to his patients. How often does one see these early ideals recede with the hard earned knowledge into the dim past, in the face of competitive economic pressure for a living? How many men would like to keep accurate case records if time allowed? How many would like to act according to their conscience and perhaps call more frequently upon patients, if this did not have the appearance of selling them-

selves and forcing their services? How many would like to follow up their cases, preventing possible serious sequallæ, if time and custom permitted?

GLORIES OF THE PROFESSION

This is the practice of medicine, except for the favored few. Does it mean an easy existence for the physician? Does it mean the best service for the public? Yet in spite of these handicaps, we find in every community many medical men performing a noble service under a tremendous burden. There is scarcely an American community without its old family physician, interested in all good movements, trusted with leadership in all vital matters, struggling along in poverty, concerned only with his obligations and opportunities for service and self-sacrifice. His example brings to us a realization that these limitations upon practical medical service, while they represent just grievances, are equally significant in reflecting the glories of the profession.

THEORY OF MEDICINE

If this is the practice of medicine, what is its theory? Does the theory more nearly coincide with our ideals of what medicine should be?

The theory of medicine has developed in three stages: First, the physician existed as an individual in the community with the sole object of *making sick people well;* second, there was added the conception that he might also *keep people well*—a social conception, requiring organization, and hence our health departments and allied social devices; third, and finally, there is being added a new idea, namely, that the physician should not only cure sickness and prevent sickness, but he should also *create health.*

As the theory has developed, socialization has proceeded to attempt to put it into practice. How well it has succeeded must be more or less evident from what has gone before. In theory the physician exists to prevent sickness and to create health. In theory he is free to act as the noblest servant of mankind. In practice he is earning a precarious and meagre living in a competitive business. Is there needed a new coat for his wife? He must pray for an epidemic. In other words, his income depends on sickness and not on health. A community educated to the social use of medical machinery would reward its physicians for an increase in health and a decrease in sickness. The doctor is now penalized for this very combination.

Yet, in the face of these mal-adjustments worthy of Alice in Wonderland, the physician continues a glorious, if somewhat blind service to duty and humanity. Strangest of all, in spite of these discouragements, the majority of physicians seem willing to fight for the privilege of economic serfdom. Can this be anything more than a gross misconception of the objects and purposes of socialization, a tremendous ignorance of the benefits that lie along the path of social organization in medicine?

OBJECTIONS TO SOCIAL MEDICINE

What indeed are the practical objections offered by physicians and others to these progressive developments in medicine? Consider only a few of the arguments presented against the social movement, arguments directed generally against the extension of social insurance, this being the line of social development most conspicuously and energetically promoted at the present time.

1. The injection of the State into the affairs of medicine will interfere with the normal relations between the physician and the patient.

Yet we have seen that this relation is largely an economic one, very unsatisfactory for both the physician and patient. The physician comes into contact with the patient only when called. He does not follow the case to a complete cure unless the patient bids him so

to do. To force his services when he alone may know how absolutely essential they are is out of the question. There is, in fact, in the existing relation very little to insure the proper care of the case, the protection of society, or the proper remuneration of the physician. There is a tremendous opportunity for improvement in this relationship. Indeed, if the present relation must be accepted as the "normal relation," then something decidedly abnormal would seem greatly to be preferred.

2. So-called "State Medicine" would seriously interfere with the physician's income.

Yet everyone knows how meagre and uncertain is the income of the average physician today. Besides, it is a reward for the amount of illness in the community, and not compensation for the amount of health preserved or created. Further, at present the physicians are performing only a fraction of the amount of work that needs to be done, and that will never get done under present conditions. For the additional preventive and creative work that should be undertaken under a reasonable arrangement, there would be supplementary remuneration for the medical profession. Socialization would quadruple the "business" of the profession.

3. Socialization would level downward.

A wise plan of State medicine, placing reward for service on an emulative basis, with a system of promotion from less important occupations (or possible districts) to more important ones, the standards being disease prevented, sickness cured and health created, would eliminate the unfit, elevate and standardize practice, increase compensation, and level upward rather than downward.

4. Socialization would eliminate "personality" from the Service.

It is true that certain steps toward socialization thus far developed do depreciate somewhat the value of personality. In hospital service this is undoubtedly a factor, the public wards being less attractive because of a relative lack of choice of physicians on the part of the patients.

Certainly, any wise system of public medicine gradually and cautiously developed along lines previously indicated, must recognize the "art" as well as the science of medicine, and must take every precaution to preserve the value of the personal elements. Of course this "personality" factor has disadvantages as well as advantages. The poorly trained quack frequently has more "personality" than the scientifically trained physician. On the other hand, higher and more uniform standards of training and practice would minimize the importance of the personal choice factor. There would be a leveling upward as to medical proficiency. Further, after all of the physicians, with the incompetents eliminated, were properly related to the community and the community's treatment facilities, such as hospitals, clinics, etc., there would be no question of inadequate hospital and medical relations, physicians without hospital connections, etc.

5. State control over the practice of medicine tends to make patients a litigation problem (particularly in health insurance) rather than a scientific problem.

In the first place, such a result could not fairly be called "socialization," for the primary aim of current social tendencies is to increase the scientific treatment of illness, to render more available the existing instruments for diagnosis and treatment, and to decrease the percentage of cases that go untreated altogether, scientifically or otherwise. As a matter of fact, the ordinary every-day practice of medicine as carried out at the present time could scarcely be made less scientific.

6. State control would make "the case" purely a scientific problem, ignoring the human factor.

This delightfully contradictory objection is often stated in the same breath with the one preceding, and answers itself.

7. Socialization tends to break down individual self-reliance, self-respect, and the willingness on the part of the patient to meet his own obligations.

It is claimed that of all the people needing or not needing treatment in a community, if treatment facilities are made too readily available and attractive, there will be a certain percentage who will take unfair advantage of the opportunity. These people, either not in need of treatment or quite able to pay adequately for private care, will fall back on the State, exaggerating trivialities, adopting malingering tactics, etc. According to the argument this is a load the State cannot afford to carry.

On the other hand under present conditions 70% or more of our population is in need of treatment, and largely fails to get it. This represents a much greater State liability and one which the State can much less afford to carry.

8. There will result a tremendously expensive and unwieldy political machine into the unsympathetic arms of which medicine will fall.

As a matter of fact, the largest element in such organization as may be necessary to administer the program of social medicine, would be the medical profession itself. Errors in the plan, defects in the provision for medical work, vicious manipulation of the system as a whole, can all be eliminated by the medical profession itself if it gets into the game in the beginning, shapes the development of the program, and contributes its constructive genius to the further growth of the whole system.

Undoubtedly it is up to the physicians to take the lead and initiative in the development of the social control of medicine. The movement should be governed from the inside and not from the outside. In this way only can the adequacy of the plan from the medical point of view be assured. Very significant is the statement of an English authority on this point (Sir Arthur Newsholme).

"It is, I think, clear that the State will year by year take an increasing hand in medical matters. It is useless, even if it were desired, to attempt to oppose the inevitable and desirable trend towards a vastly increased utilization by the State of medical science in the interests of humanity. It is for physicians to guide the course of events, and to insure that no plant is sown which will afterwards need to be uprooted; that no development is permitted which will hinder the fulfillment of our ideal."

BENEFITS OF SOCIALIZATION TO THE PHYSICIAN

A few of the many advantages of a further social control of medicine to the private physician may be summarized briefly here. A social system properly planned should insure more regularity of service as to hours, a tremendous increase in the amount of worth-while work accomplished, an enhanced income, a reward on a rational basis of accomplishment, better opportunities to study and specialize, opportunity for expert consultation and coöperation, and the elimination of the necessity for frequently putting economic consideration ahead of the patient's welfare.

The individual trained to treat the ills of his fellow-man should be assured of an adequate income, not dependent on a chance excess of illness in his community. In medicine the relative cost factor should be eliminated both for the patient and the physician. Society cannot afford preventable illness. Society cannot afford to leave its elimination to a haphazard system in which the patient and the doctor make their decisions under the pressure of economic necessity. This ideal is approximated

even now in one form of socialized medical service, namely, the hospital. Here there are, for instance, laboratory and research facilities for all, rich and poor alike, and the cost factor is partially at least eliminated, the basis being service. The socialization of medicine should eventually eliminate from the physician's life this hampering element of economic pressure. The man who is teaching medicine as well as the man who is practicing it, should be free from worry and undue stress on the side of self and family maintenance.

BENEFITS TO SOCIETY

Equally obvious must be the advantage to society. Through socialization in its many phases, every individual should receive the advantages of special facilities and expert service, regardless of his paying ability. From the social point of view, preventable sickness always is too expensive. We could afford to obtain medical service at any cost for the 70% in need of it, and not only for the few who can now afford it. If it is cheaper "to prevent than to cure," and if "a stitch in time saves nine," then the prevention, early detection, and adequate treatment of disease will materially lower the charges upon the community for illness costs. Finally, society would be operating on a rational, economically sound basis, utilizing its medical resources to the full.

THE MAIN FACTORS IN THE PROBLEM

To summarize the outstanding factors in the socialization problem:

1. The problem is an extremely difficult one, dealing as it does so extensively with the human factor. It would be a stupendous error to leave out of the reckoning the element of human psychology in such an enterprise. Because of the difficulties, there are bound to be errors, false starts and partial failures.

2. The program needs the coöperation and guidance of the medical profession. To succeed, it must have their study, sympathetic criticism and constructive aid. For all of the medical work of the world, the medical examination work, hygienic education, the work among infants, in schools, in factories, etc., there will be necessary a most efficient system of medical service. Plans must be made to provide wisely for the increase in numbers of medically trained individuals needed under social control.

3. The medical profession is social in spirit, though in need of socialization as to method. Not so much can be said for the spirit and attitude of the general public toward the service which it expects from the medical profession. There is greatly needed an infusion of the spirit of service and community responsibility for disease control into the great mass of people everywhere. At present each individual thinks of his private health as a private matter. He calls the doctor only when he is sick—and frequently waits until 2 A. M. to do that. He wishes to maintain his earning capacity and avoid pain, but has very little sense of duty to keep well as an obligation to society. He does, however, think it is the duty of the doctor to make him well after he becomes sick—once more the duty being altogether on the side of the physician.

The physician has never had a real chance in social organization. He is only given the sick and relatively discouraging individuals to look after. He has never had an opportunity to keep the community well, to do a genuinely fundamental job.

In one of our largest cities, there are 10,000 physicians treating individual cases of illness and 300 or so (in the Department of Health, mostly on part-time) enjoying the privilege of keeping the whole people well. All should participate in this privilege.

The physician has been given a disagreeable, if not impossible task—that of putting together the pieces. It is to be hoped that before long he will de-

mand of the public the opportunity to share in the operation of community life as a whole. This apparently is dependent on the development of a spirit of service, a social attitude on the part of the public he seeks to serve. Little by little this *will to be healthy,* this essential counterpart to the spirit of service in the medical profession, is becoming a reality.

The object of medicine is a healthy community life. Up to the present time, however, the doctor has been expected to do all the work, either individually or through the gradually developing medico-social organizations. It is essential that we all do our part. The results of this inter-play and community of spirit will be an increased scope for the medical service, better training, greater uniformity of methods and higher standards of practice.

THE SPIRIT OF SERVICE

In conclusion, what must be demanded are a maximum service for the sick regardless of their ability to pay, and a chance for the physician to give maximum service in disease prevention, treatment, and cure. The medical profession must be aroused to its opportunity and obligations. State and county medical societies, as well as the American Medical Association, could with advantage appoint commissions to study the whole problem of social tendencies in medicine, not only the health insurance piece-meal aspect of it. The problem should be approached with a sympathetic spirit of digested idealism. Certainly it would be a more valuable contribution for a medical society to study current needs and practices, to formulate a program, to help work it out in coöperation with social and health organizations, than, ostrich like, to stick its head in the ground and protest with its heels by the passage of a futile anti-health insurance resolution.

Let us remember that social medicine means the organized effective use of medical facilities, the rendering available of these facilities for all people in need —a service basis. This does not mean "state medicine," so-called. Any group in the community may employ medical devices socially. The school committee that employs a school doctor, the factory group engaging an industrial physician, the town or county civic or health committee or tuberculosis society that offers expert consultation services to the physicians and the people, the state department of health that districts the community for treatment purposes in influenza epidemic times, the state university, or state medical society, that attempts the post-graduate education and standardization of the medical profession—all of these movements, any collective movements that tend to improve and stabilize medical service, that render more nearly all of the resources of medicine available, for the masses of people, particularly for disease prevention and elimination, are social medicine. Social medicine is therefore simply community medicine. It may be under official or private auspices, local, state, or national control! Above all, it is not only health insurance. Indeed, experimentation might prove this particular device to be anti-social in character. The final test of any program is service rendered.

Social medicine will never spring full grown from the lap of the existing chaos. A practical working program must be conceived—a program through the gradual execution of which all may learn to "breathe the ampler air of service."

In the January issue of the JOURNAL will appear the Symposium on Narcotic Drug Control as presented at the San Francisco meeting of the A. P. H. A.