The founding and growth of the Medical Care Section is outlined, and the influence of various factors upon its emergence into its present day status is discussed.

Emergence of the Medical Care Section of the American Public Health Association, 1926-1948

Arthur J. Viseltear, Ph.D., M.P.H.

In order to build its own future, each generation must learn both to utilize its past and to escape it.

—Michael Davis, *Medical Care for Tomorrow*. New York, Harper and Brothers, 1955, p. 434.

This paper will consider the biography of a movement and its attendant joys, frustrations, modifications, and impact. It is not intended to be a paean to great men; nor will it convey meaningful lessons, moral or otherwise. As is indicated by the paper's subtitle, the history of the Medical Care Section will be seen in a broader context since notable events or movements rarely occur spontaneously but are rather the result of a peculiar confluence of political, economic, social, and personal factors and ideologies, some of which are rational, some emotive, some expectant, and some novel. An attempt will be made to balance internal and external factors and historical trends, focusing on the internal structure of APHA and especially the Committee on Administrative Practice's Subcommittee on Medical Care, the external forces which upset the equilibrium of the parent institution, and certain historical trends which led ultimately to the emergence of the discipline we commonly call medical care.

Preface

Meeting in Mechanics Building, Boston, on November 10, 1948, the Governing Council of the American Public Health Association voted to approve a petition requesting the establishment of a Medical Care Section. The minutes of that session, unfortunately characteristic of the monosyllabic and prosaic style that typifies organization minutes, describe the event as follows:

> Dr. Leavell moved that the Governing Council approve the plan [to establish a new Section] . . . The motion was seconded.
>
> In the discussion that followed, Dr. C. Howe Eller . . . presented [a] resolution "That the Council of the Health Officers Section . . . go on record that it feels that it is not advisable to establish an additional special section at this time."
>
> Dr. Haven Emerson was recognized and presented an opinion against the creation of a new section . . .
>
> Dr. George T. Palmer expressed his opinion favorable . . .
>
> Dr. V. A. Getting . . . expressed an opinion favorable . . .
>
> Miss Ruth Freeman . . . spoke in favor of the creation of a section.
>
> Upon request of Dr. Leavell, Dr. C.-E.A. Winslow expressed his opinion as favorable . . .
>
> Following the discussion, the President put the question and . . . the motion was carried by a vote of 55 to 16.

The petition which Dr. Leavell had submitted, considering its potential importance, was a disappointingly perfunctory document. It made plain that APHA already had evidenced an increasing concern with medical care at its annual meetings; that it had sponsored studies of the Committee on Administrative Practice's Subcommittee on Medical Care; and that it had endorsed the latter's policy statements on "Medical Care in a National Health Program," on "Planning for the Chronically Ill" and on "Coordination of Hospital and Health Departments." A new Section on Medical Care, it was believed, would provide "a valuable and much needed organizational medium" for individuals working in health care and health related fields; would "mobilize the unique scientific tradition" of APHA for the "technical advance of medical care;" and would facilitate necessary and mutually beneficial working relationships with other sections within APHA. Additionally, it mentioned that there already had been a profound interest in the Section on the part of hospital administrators, hospital plan executives, state hospital program directors, medical care social workers, directors of voluntary and public medical care plans, specialists in rehabilitation, outstanding clinicians, and others comprising the field of medical care. The peti-

tion concluded with a list of officers for the proposed Section and was signed by 32 fellows and members of APHA.

The rather simply worded petition and the prosaic minutes describing the favorable vote of the Governing Council belie the intensity and duration of the debate, dating back to the early decades of this century, which reached its climax on that rainy November afternoon in Boston.

Early Developments

Health services—their needs, demands, and forms—have changed over the years. As old problems were solved, new ones or those unappreciated in the past arose to take their place. But what exactly had been the concern of public health? The principal objective of APHA in 1872, as expressed in its Constitution, was the advancement of sanitary science and the promotion of organizations and measures for the practical application of public hygiene.[1] The first task of public health, then, was environmental sanitation and its central figure accordingly, the engineer. In the 1890s, the bacteriologist emerged as the dominant figure, and, when it was recognized that certain diseases could be prevented by hygienic living, the promotion of personal hygiene came to be recognized as an integral component of public health. Based on sanitation, bacteriology and education in personal hygiene, the modern public health program crystallized in the first decades of this century into a definite and concrete form.[2] But despite the rigidity of concept, there was no order. Administrative health practice was instead a medley of local and accidental enterprises. To resolve this problem, APHA in 1920 appointed a standing committee to study municipal health departments and to determine the extent of variation in procedures and services offered in specific communities.[3]

The Committee on Administrative Practice

In 1925, the Committee on Municipal Health Department Practice, which had been established in 1920, was reorganized, placed on a permanent basis, and its name changed to the Committee on Administrative Practice to indicate a broadened scope of interest. CAP constituted the technical service division of APHA and was concerned basically with collecting data, formulating and promoting adequate community health service programs, and evaluating and securing public backing for such programs, by using standards and comparative ratings to stimulate emulation between various local areas.[4]

CAP in the mid-twenties busied itself with questionnaires and surveys, developed the now-classic Appraisal Form for City Health Work,[5] attempted to standardize the collection of vital data, developed model ordinances and a standard form for preparing annual reports, and sought to determine just how effective current health department procedures were in lowering morbidity and mortality rates.[6] What CAP did not do, however, was boldly enter the realm of medical care.

Compare, for example, two presidential addresses delivered before APHA. Henry Vaughan, then Commissioner of Public Health of Detroit, in 1925 believed that the primary concern of APHA should be the recruitment and training of sanitarians and the development of standards of work to improve scientific techniques. Despite the title of Vaughan's address, "An Association With a Future," a goodly portion of his speech was devoted to past achievements and past goals. Vaughan's Association of the future would be comprised of a heterogeneity of health professionals devoted to the task of advancing the sanitary and allied sciences. The possibilities of service as sanitarians in a common profession, he concluded, were immense and every possible effort should be made to continue in this direction. Medical care was not included in Vaughan's vision of the future.[7]

C.-E. A. Winslow one year later pointed to the unprecedented successes and outstanding achievements of the Association, as had Vaughan, but chose as his theme the necessity to adopt new methods in order to meet new demands. Public health, said Winslow, was at the "crossroads." It had now recognized as legitimate concern the responsibility for medical care of communicable diseases and for the hygiene of the infant and the schoolchild, but he wondered if those in public health should attempt to determine the point at which social responsibility for the care of individual health ceased? Indeed, did such a point exist? Could boundaries be established between prevention and cure? Should the health officer concern himself only with communicable diseases or could the Association envisage a wider health program embracing the entire field of prevention of disease and the promotion of physical and mental health and efficacy? To such questions, Winslow gave no answers. But his phrasing and the questions themselves indicate his awareness of the need for modifications of the standard health department program.[8]

Despite such differences as already have been noted, the major distinguishing feature between both addresses was Winslow's lengthy consideration of medical care. Certainly, problems of medical care had emerged prior to the mid-twenties. Concern with need, inadequacies and inaccessibility of health services, the cyclical relationship between poverty and illness had all been described in detail in the many medical economic surveys and social commission reports of those states that had considered social insurance legislation in the early decades of this century.[9] Before the Association itself, papers had been read on the social aspects of health and the need for rationalizing a confused health care system.[10] But Winslow's presidential address had given credence to problems about which the Association previously had chosen to remain oblivious, such as the fact that medical practice had become increasingly complex, that rural areas were often without the services of physicians, that the high cost of adequate care had created a financial barrier between consumers and providers, and that medical services had not become preventive in nature but rather alleviation after the event. He also considered group practice, health insurance, and comprehensive health planning, warned against the use of catchwords such as "socialistic" or "bureaucratic," and further noted that organized community medical services were coming "as surely as the sun will rise tomorrow."[11]

It was these concerns that had prompted Winslow in the early twenties, as chairman of the Committee on Administrative Practice, to appoint a special subcommittee to consider a single medical care-related problem, the relation between the health department and the local hospital.[12]

The Subcommittee on Organized Care of the Sick

With men and money co-opted from the Committee on Administrative Practice and the American Hospital Association, the Subcommittee on Relations of Health Departments and Hospitals (which in 1926 became the Subcommittee on Organized Care of the Sick),[13] under the chairmanship of Michael Davis, collected information and issued reports in the late twenties and early thirties regarding the extent and form of cooperation between hospitals, dispensaries, clinics and health departments in the fields of laboratory examinations, hospitalization of patients with communicable diseases, and maintenance of public health clinics.[14] The Subcommittee limited its studies to community needs and preventive work, and avoided any consideration of the internal administration of hospitals or the personal diagnostic or therapeutic care of patients by their physicians in hospitals or clinics, choosing instead a less controversial program which included the study of such matters as the need for hospital beds, clinics or other organized curative facilities of a community; the social and economic groups for whom such facilities were needed; and the geographical distribution and the interrelationships of these facilities to one another and to other interests and agencies of the locality.[15]

The Subcommittee included, from its creation, three health officers, one professor of health administration, and three members nominated by the American Hospital Association, and relations with the parent Committee on Administrative Practice were reported to have been cooperative and satisfactory. But differences of opinion as to the wisdom of entering the medical care field developed within CAP. As early as 1927, for example, Winslow had asked members of the Health Officer's Section to consider if there should be "restrictions or extensions" upon the type of surveys envisioned by the Subcommittee, and Davis specifically had noted that the objectives of his Subcommittee—to plan a general scheme of community surveys, including organized facilities for the care of the sick—were subject to revision if the membership so desired.[16]

At this time the Committee on the Costs of Medical Care had just begun its studies of the health problems of the nation. With funding from eight foundations and cooperative endeavors from all major health associations, the U.S. Public Health Service, and state and local departments of health, the CCMC, between 1927 and 1932, prepared 26 reports and a final document, *Medical Care for the American People.** The recommendations are well-known and need not be repeated here except to cite from the second recommendation calling for the extension of basic public health services, whether provided by governmental or nongovernmental agencies. The extension of the services of the health department into the realm of personal health services became the subject of many heated debates within APHA and certainly within CAP. The issue, which recurs throughout the thirties and forties, was whether public health was to be concerned with only prevention while treatment remained the prerogative of private medical practice. That public health would lose sight of its basic goals by expanding its scope, or be rendered inoperable if it chose to confront organized medicine, had caused health officers, many of whom served at the sufferance of local medical societies, to be fearful of accepting any variance in a traditional interpretation of public health.

In the introduction to the final report of CCMC, Ray Lyman Wilbur expressed his hope that, when CCMC concluded its activities, some other organization would concern itself with promoting and coordinating subsequent medical economic research. Michael Davis recognized the importance of Wilbur's statement and wished to adopt it as a charge to his Subcommittee on Organized Care of the Sick. But by 1933, when the Subcommittee had reached a point at which it wished to apply CAP's surveys as well as to develop those studies as envisioned by Wilbur, discussions of matters of policy became more active and differences of opinion were made sharper by public issues concerning the expansion of public health work, as recommended by CCMC, and by the national social security proposals. At a meeting of CAP held in New York in December 1935, Davis appears to have given up hope that the Subcommittee could continue as a viable force within CAP. He reported that the general problems of public health involving the organized care of the sick were matters for the consideration of CAP as a whole rather than for a subcommittee. He noted further that the purpose for which the Subcommittee had been created had become routinized. Additionally, the hospital appraisal form which had been developed by the Subcommittee soon was to be taken over by the American Hospital Association. For these reasons it seemed logical to Davis to recommend to CAP that the Subcommittee on the Organized Care of the Sick be disbanded.[17]

The Subcommittee remained in a state of limbo throughout the late thirties; but in 1939 there was talk of resuscitation. By this time the ferment in Washington and throughout the nation with respect to medical care had led the Association to the inescapable conclusion that medical care was indeed a subject of vital concern and one on which the Association would very likely be called upon to express its position in the immediate future.

Before continuing the story of the evolution of the Subcommittee, and its subsequent emergence as the Subcommittee on Medical Care in 1943-44, it would be wise to discuss briefly certain external developments occurring in the late thirties which coincided with APHA's decision to consider seriously the field of medical care.

The Thirties

In the mid-nineteenth century, Lemuel Shattuck and his associates recognized that public health was a social phenomenon and that its emphasis should be on man as a social being and as a product of a social environment.[18] Henry Sigerist, in the early thirties, similarly believed that there were social aspects to medicine and public health that somehow had been submerged as public health had become compartmentalized and categorized and the practice of medicine burdened with market-place considerations. Addressing the Third Eastern Medical Students Conference in 1936, Sigerist noted the changes that had occurred in the world.[19] Society, he said, had been transformed by technology and had become industrialized and urbanized. Medical

* Reprinted in 1970 by the U. S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, Community Health Service, Washington, G.P.O., 1970. The reprint is enhanced by a preface written by I. S. Falk.

science similarly had become highly technical and highly specialized. To survive such changes, said Sigerist, society would have to adapt rather than to preserve the old forms of medical practice that had been suited to a society and to a medical science that no longer existed. Yet he had witnessed precious little adaptation, which prompted his comment that it was not enough to observe and interpret what was wrong with society; one rather had to change society in order to improve it.[20] And this, then, was the task Sigerist set for the younger generation of physicians in the thirties. He implored them not "to stand aside" but to become involved in the social aspects of medicine; to study history, sociology, political science, and economics.[21] Once medical students understood these subjects, and additionally understood the tendencies and trends of society, they would be able, Sigerist believed, "to accelerate the developments and to make this world a better world."[22]

John Peters of Yale also had a vision of medical practice. We should all work toward the development of "medical utopia," he said to the same conference of medical students Sigerist had addressed one year earlier.[23] Peters' utopias of community medical service were to be characterized by "the broadest dissemination of hygienic knowledge; in which each physician was vitally concerned with the well-being of all of the people; in which the widest preventive measures were employed." But to effect this change, physicians would have to apply the same scientific spirit with which they face any individual clinical case or laboratory problem.[24]

Peters characterized himself as a "radical," though he preferred to think of himself merely "curious and intelligently open-minded."[25] But whereas Sigerist had immersed himself in the messy business of politics in support of social causes such as compulsory health insurance, Peters hesitated. It would be instructive to consider momentarily the more idealistic Sigerist and the more pragmatic Peters, as both are characteristic of the emerging attitude toward medical care of the late thirties.

Sigerist, Peters, and Social Progress

Sigerist's conception of medicine was the study and application of biology in an historical matrix which simultaneously encompassed social, political, economic, and cultural phenomena. For him, medical practice was an integral component of sociology and an outgrowth of sociological factors. At the Institute of the History of Medicine in Leipzig and later at Johns Hopkins he accomplished an indefatigable amount of historical research but chose not to limit himself to medical historiography. The history of medicine for Sigerist was a means to analyze the past in order to orient to the present and foresee the future.[26]

Sigerist was indeed a commanding figure. Philologist, humanist, medical sociologist, and historian, his charm, wit, urbanity, and elegant manner soon captivated the young men and women who attended the annual conventions of the Association of Medical Students, and especially those who attended his seminars on the sociology of medicine at the Hopkins Institute of the History of Medicine. One such seminar traced the developments of the medical profession, and past attempts at medical organization, and ended with the contemporary scene. Topics included the development of the position of the sick man and the physician in society, medical service in ancient societies, the rise of capitalism, political philosophy and medicine, and the American situation with respect to medical economics and experiments in medical organization.[27]

Sigerist, however, was not content merely to discuss past and contemporary topics; rather, he followed his own admonition to his students for careful study and for advocacy. Throughout the thirties he analyzed the medical care scene and came to the conclusion that radical change was necessary. As a result of four years of study and two summers of extensive traveling in the USSR in 1935-1936, he prepared a treatise on socialized medicine in the Soviet Union in which he strongly supported the merits of that country's system of medical care.[28] He wrote articles on socialized medicine and compulsory health insurance for scholarly journals, popular magazines and newspapers,[29] and delivered an address at Town Hall on the topic "Does America Need Compulsory Health Insurance?"[30] At the Hopkins, he dedicated his life to scholarship; as an advocate for change, he displayed a similar dedication and commitment.

While Sigerist was exposing medical students to historical method, the principles of health insurance, and the social sciences at the Hopkins, John Peters of Yale was likewise concerned with social change. Peters was one of the foremost medical scientists of his generation. He has been characterized as "a man of selfless rectitude who never spared himself . . . , believed in the equality of all men and in their basic rights in society, and [who], in the face of any seeming injustice . . . , never hesitated to voice his opinions." As a scientist his credentials were impeccable. He published in his lifetime more than 200 scientific articles; but was also known as "an ardent disciple of full-time medicine." Best known professionally as a biochemist, Peters also took great pride in his work as a practicing doctor. As attending physician at the New Haven Hospital since 1921, he was known rarely to have missed making daily rounds.[31]

In 1936-37, Peters and a group of progressive-minded physicians had formed an organization known as the Committee of Physicians for the Improvement of Medical Care. Some 430 physicians issued a declaration of "Principles and Proposals" designed to stimulate public discussion of medical care problems and to indicate to the public that professional thinking on public questions may not always be the same as the "official" pronouncements of AMA and its constituent societies.[32] The Committee had noted that AMA had incurred the enmity of the public because of its obstructionist position and that lay bodies interested in social questions had been pressing the government to impose some program for medical care without the expert advice of physicians. Confronted by a status quo professional organization on the one hand and a "change at any cost" mentality on the other, Peters believed it necessary to prod the profession to protect itself and take the initiative in public service in its own field. He especially wanted to keep medical care out of the hands of professional politicians, exploiters, publicists, talkers, and promoters—those who were "possessed by preconceptions and wish-complexes." He believed rather that the members of the professions who were "most alive" to the errors of the system and who were "intimately acquainted with its details" should be the ones

responsible for setting directions.[33] Peters, then, was very definitely for change; but it was for a moderate, gradual change directed by objective, dispassionate, and experienced practitioners.[34]

Peters had not been alone in his appeal for the application of scientific method to medical care problems. Michael Davis, of whom mention already has been made, also had cautioned against accepting change for its own sake. An immensely energetic and practical man, Davis had been able to gain foundation support for a Committee on Research in Medical Economics a year after he had recommended the disbanding of the Subcommittee on Organized Care of the Sick. Recognizing the rather dynamic trends in medical care, he hoped to provide current medical care activities "with guidance rather than impetus." Opposition by organized medicine to group practice, the extension of tax-supported medical and public health services, and voluntary and compulsory sickness insurance, he believed, had not been as inclusive as generally had been supposed. But rather than capitalizing on such variations in thinking, the rank and file of the medical profession and even the leaders taking part in the advance of public health work, public medical services, and group practice had continued to proceed opportunistically by meeting immediate situations one after another.[35]

To correct such opportunism, Davis recommended the development of specific research projects which he believed might assist those responsible for the design and implementation of medical care policy. The projects were to be in the general areas of evaluation and medical economics and to consider specifically capital investment and capital costs in medical services, economic analysis of medical service as a public utility, theory and demand in application to medical services, value and privacy of medical services, the economics of the X-ray business, hospitals as social institutions, and the ecology of rural practitioners.[36]

His program was rather ambitious and additionally paralleled similar research endeavors by various public and private agencies, but although derivative, Davis appears to have resurrected CCMC's idea to channel the considerable talents and skills of researchers from various cognate disciplines into the fields of evaluation, medical economics, and, in general, the quantification of data upon which rational medical care practices could be developed.

All three—Sigerist, Peters, and Davis—had recognized medical care as a legitimate scholarly discipline and each in his own way reacted to the need for medical reform based on the system in which they had operated. Sigerist, for example, believed in the inevitability of reform once society had become educated to the intrinsic merits and rationality of a new medical care program; Peters was for reform, but only if physicians developed and controlled the program; and Davis advocated a reform based on critical study, evaluation, and demonstration. At the same time that such concepts were developing, the subject of medical care came before the American people by virtue of executive fiat.

The National Health Conference

The National Health Conference was convened in 1938 at the invitation of the President and his Interdepartmental Committee to Coordinate Health and Welfare Activities. Created in 1935 by President Roosevelt following the passage of the Social Security Act, the Interdepartmental Committee had been given the charge to insure that the full benefits of the various federal programs under the Act's provisions might reach "with minimum delay and maximum effectiveness" the men, women and children for whose aid and service the program had been brought into existence. The Committee[37] was both impressive and extraordinary in that representatives of five government departments—Treasury, Agriculture, Interior, and Labor, and the Social Security Board—had been asked to work together cooperatively and harmoniously and, as C.-E.A. Winslow noted, actually did so.[38]

The Interdepartmental Committee was assisted by a Technical Committee on Medical Care.[39] Under the chairmanship of Dr. Martha Eliot, then Assistant Chief of the Children's Bureau, the Technical Committee had brought out findings on the health needs of the nation. These findings had been based on the Committee's own research and on the results of the first National Health Survey. Sponsored by the Public Health Service with the cooperation of the Works Progress Administration, the survey covered some 800,000 families, or 2.8 million people, and reported rather startling results. Unemployment, starvation wages, indecent housing, and utterly inadequate diets were confirmation of the extent to which human and economic waste had been permitted to go.[40] The reports revealed that medical care varied with income; that over four million were disabled by illness each year; that 70 million sick each year lost more than one billion days from work; that in 1935, for families with incomes less than $3,000, 47% were acutely, and 87% chronically ill; that each year 40,000 died from tuberculosis; that the total annual cost to the United States for illness was $10 billion; that industrial workers had a life expectancy eight years less than non-industrial workers; and so on.[41]

The Technical Committee formulated conclusions for a program which would cover the areas of public health and maternal and child welfare, hospitals, the medically needy, and two final recommendations dealing with a general program of medical care and disability compensation. Under the recommendation for a medical care program, the Committee advocated the insurance principle, noting that medical care would never become available to families with small or modest incomes at costs they could afford unless the costs were spread among all groups of people over periods of time. The savings made possible by the insurance approach, the Committee believed, would considerably decrease the annual health bill. Government aid to finance the plan was necessary, and in developing state plans for a general program of medical care, alternate means of raising funds—by taxation, by insurance, or by a combination of the two—and the extent of federal grants-in-aid to states would have to be carefully considered. In the final recommendation, the Committee supported disability compensation, believing that the continuity of wage earners' incomes and purchasing power was an important part of any program for national health.

In offering the Conference its recommendations, the Technical Committee intended only to open the subject rather than to present ideas in hard and fast form. Its object was to collect facts, calculate the cost and then "to present recommendations for public discussion so that the demo-

cratic process of national policy-making could begin to function, accepting, rejecting, modifying, combining, supplementing the proposals that had been prepared."[42]

Criticism of the program, nevertheless, was inflammatory. Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* pointed out at the conference how "truly healthy" the American people really were, the National Health Survey results notwithstanding. Morbidity and mortality rates, he believed, compared favorably with those of any nation in the world, "regimented or unregimented." Moreover, he questioned the ranking given to medical care, intimating that the government should first consider food, fuel, clothing, shelter, and employment. But AMA, he insisted, was not there to refute the statistics or the recommendations, although he was quick to note in an aside that he could do so if requested. Rather, Fishbein considered that his job was to find out if society could "depend upon such a program in charting future progress." If not, then a new program would have to be developed; one that would take into account established insurance company programs, the sickness and hospitalization plans of voluntary societies, and of the non-profit voluntary hospitals.[43]

As usual, the bugaboos of "political domination," "bureaucracy," and "federalization" had been raised. Dr. Alice Hamilton responded by pointing out that the federal government was not an "invading hostile power" that knew nothing about the needs of the country. "After all," she asked, "what is the federal government? It is ourselves—ourselves organized."[44] Winslow also spoke in a similar vein. Without a prepared text, he first pointed to the fact that the report of the Technical Committee did not call for a program of health insurance, nor for an extension of medical service, nor for hospital construction; but rather for "a coordinated, completely interlocking, dove-tailing health program for the nation in which all these things have their just and proper part." Concerned also about the bugaboo of "federalization," Winslow corrected the assumption that the federal government was "a peculiar, strange kind of foreign body intruded into these United States by some mistake." The government rather was the organ through which he and all citizens could function.[45]

The American Public Health Association had been alive to the implications and scope of the federal activities. In April 1938, the findings of the Technical Committee on Medical Care were discussed in a comprehensive *AJPH* editorial,[46] and, in October, the Association passed a broad resolution in which it endorsed the recommendations of the Technical Committee providing for federal aid to states, construction of facilities, expansion of public health services, and establishment of sickness compensation. APHA further pledged its professional resources to aid governmental agencies to achieve the "statesmanlike" health objectives expressed in the Technical Committee report and to translate promptly the principles of the National Health Program into effective action."[47]

Additionally, the resolution called for the creation of a special committee which would "cooperate" with the Interdepartmental Committee as well as with AMA, American Dental Association, the National Organization for Public Health Nursing, and the Conference of State and Territorial Health Officers.[48] In November 1938, the APHA Committee[49] met in Washington with Josephine Roche, chairman of the Interdepartmental Committee, to discuss the relationship of the National Health Program to the work of the public health profession. Abel Wolman, chairman of the APHA Committee, presented recommendations which dealt especially with federal-state relationships and the role of state departments of health.

The APHA Committee believed that the single state agency best suited to carry out all the provisions of the National Health Program which might be enacted into law, in terms of integrating and coordinating services, providing qualified personnel and maintaining high professional standards of medical care, was the state health department. It was recognized, however, that funds would have to be provided for training purposes and adequate provisions would have to be made for technical staffs and administrative expenses. The committee further believed that the proposal was in accord with the recommendation of the Interdepartmental Committee that the envisioned program "be developed around and be based upon existing preventive health services."[50]

Also discussed at this meeting was the APHA Committee's recommendations that, in the initiation and development of the program, wide latitude be given to the states; that the fundamental objectives remain the conservation of health and vitality and the reduction of the role of sickness as a cause of poverty and dependency; that quality standards be developed before federal funds are awarded to individual states and local areas; and a final belief "that the extension and improvement of public health services in general throughout the country requires complete integration of health services of the federal government under one cabinet officer, preferably a Secretary of Health."[51]

At the conclusion of the National Health Conference, it was apparent that what change would come would depend upon the support given the program by those referred to as "insistent consumers."[52] By 1932, the Committee on the Costs of Medical Care had produced reams of data upon which to base effective action, but the data had not reached the population. In 1939, to some degree, it was thought that they had. The next order of business, then, was the drafting and submission of a bill which incorporated the essence of the recommendations of the National Health Program envisioned by the Technical Committee on Medical Care.

The Wagner Bill

The National Health Conference revealed the sentiment that economic forces had been germinating a new point of view on the subject of medical care. Dr. Joseph Mountin, a member of the Technical Committee, believed that the "many signs and rumors from forum, press, radio, and private speech, from grand staircases and back porches," indicated that many people, individually and in groups, were disinclined to leave medical care in the category of purchaseable commodities. Medical care rather was increasingly being regarded, he believed, "as a means to a healthier existence, to be dispersed by society for the good of its members."[53]

The Wagner Bill, submitted to Congress in February 1939, represented just such an awakening interest in human health and a desire to place the resources of government behind the movement. Wagner's bill (S. 1620) was an

amendment to the Social Security Act whereby Titles V and VI of the Act were to be amplified and additional services provided under three new titles (XII, XIII, XIV).[54] Title V was to remain essentially the same as its corresponding title in the 1935 Act in its provision for maternal and child welfare and care of crippled children, but would additionally include general medical care during the maternity period and childhood. Title VI sought to develop further the administrative structure for an enlarged health program by strengthening existing state and local health departments. Preventive programs of health departments in fields of community health and sanitation were to be augmented and made more effective. Special mention was made of mental and industrial hygiene, malaria, tuberculosis, cancer, and pneumonia. Research by the National Institutes of Health was accorded a separate section under revised Title VI and carried authorization for increased appropriation. Title XII contemplated a material increase in the number of hospital beds and of health centers; Title XIII was designed to provide medical care for such groups as the individual state might choose to cover by its system; and Title XIV expanded the concept of unemployment insurance to cover wage loss due to incapacity arising out of illness.

The program was permissive in that each state was to determine the content and the population groups within its borders to be covered, together with methods of finance and administration, as had been indicated in the Technical Committee report. It was deemed the purpose of the federal government to assist the several states through financial grants-in-aid, provided that the states developed plans which met the requirements which would insure quality of service and judicious expenditure of public funds. Contrary to public impression, the bill included no appropriation; being enabling legislation, it merely set a limit on the amount that may have been expended during the first two years of operation.

In commenting on this bill for the *Interne*, Mountin noted that "whatever may come of pending legislation the time appears to be ripe for some type of change in the distribution of medical services; the population is on the quivive."[55]

Though the population may have been on the alert, so too were representatives of the medical and public health professions. The different points of view of the witnesses called to testify before the Senate Subcommittee on S.1620 are indicative of the struggle within APHA, which had begun in the twenties and was to reach its climax in the forties, with respect to the acceptability of medical care.

Haven Emerson, Joseph Mountin, and Social Progress

In 1939, Haven Emerson was one year away from retirement. His career had begun when there had been no such thing as a profession of public health. In the early decades of the century he contributed to the fields of epidemiology and vital statistics, and from the early twenties to the early forties he occupied the chair of public health administration at Columbia. He served as president of APHA in 1934 and one year later was honored with the Sedgwick Memorial Award.[56]

In his presidential address in 1934, Emerson cited three elements necessary to assure further improvement of human health: "Some increase in effective intelligence; something of the spirit of religious devotion even to the point of self-denial in the material possessions and accessories of today's life; and lastly, courage to apply what biology has taught us to believe."[57] When discussing the last of his suggested "trio of collaborators;" namely, "courage to invent, to test, to apply; courage of society to demand those services which science is ready to perform," he cited from Buckle's *History of Civilization* that "The great enemy of knowledge is not error but inertness." For Emerson in 1934, the vision and leadership of APHA were to counter "social inertia and cowardice" with regard to health issues such as personal and environmental hygiene, syphilis, marriage counseling, alcoholism, diabetes, and occupational diseases.[58] But the courage to invent, test, and apply ceased when the topic changed from preventive to curative medicine.

Before the Subcommittee on S.1620, Emerson's testimony reflects his view of a limited public health. There was no need to support the legislation proposed by Wagner since there was no emergency of sickness or neglect abroad in the land. If there were to be change, better it be along well-established lines in the orderly evolution of social and professional resources made available by new medical knowledge. He advised against disturbing services, which over the years had proven successful, by creation of another policy where local responsibility would be largely at the mercy of federal dominance and allocation of funds.[59] He questioned the reports of excessive sickness, stating that they were much exaggerated and additionally noting that the possible benefits from large additional expenditure were too optimistic and problematical to be convincing. If the federal government wished to contribute to the general health, he had said, let it reestablish confidence in self-support, and encourage private industry, earning capacity, and productive employment.[60] When asked by Senator Wagner if he doubted that federal aid had reduced morbidity and mortality, Emerson replied that when he was born, the infant mortality rate had been 250; in 1939 it was 38, revealing a "continuous and uninterrupted improvement regardless of any federal intervention in local health services." "Are there occasions where the federal government ought to aid health?" asked Wagner. "Yes, public health service grants-in-aid for the extension of full-time county health services and sanitary improvements have been helpful in the past," replied Emerson.[61] When Senator Ellender asked if he favored federal grants for preventive medicine only, Emerson replied:

> I believe that to be the first object. I do not believe it is the function of the State or National Government to take care of women in confinement or to take care of babies or to take care of other things which are the functions of the practice of medicine and which can be better handled by local communities than by aid from Washington. I believe the most intelligent expenditure of what you might call stimulating money for the health of the Nation would be in the field of prevention rather than in the field of care of the sick.[62]

Emerson represented only himself at the hearings; Abel Wolman spoke for APHA as its president. For the most part his testimony was similar to the recommendations made a year earlier to the Interdepartmental Committee.

The APHA statement, however, brought out points similar to those raised by Emerson; for example, permitting the states to determine the population they wished to serve and the methods of providing the public health, medical and hospital services; APHA's belief that the program, in its essential features, should "rest upon the local people" and not be "handed down from above" by the federal government; and that the primary function of the government should be to give financial and technical aid and not be responsible for the administration of the program.[63] Wolman, however, in his prepared statement,[64] listed those features with which APHA was in accordance, concluding that the Wagner Act had met the recommendations of APHA in "practically all respects,"[65] and additionally stating his belief that the National Health Act of 1939 "can be approved as a device to implement the National Health Program."[66]

The issues, however, were more intense than had been expressed before the Senate Subcommittee. Nowhere were they delineated so well as at an APHA General Session in October 1939 on "Medical Care and the National Health Program." Here Haven Emerson and Joseph Mountin read papers which epitomized the two viewpoints that went to the very core of APHA as an institution.

What exactly was the role of APHA? Emerson believed that APHA should reemphasize its scientific tradition and not be swayed by emotion; it was the business of science, he said, to discover truth not salvation.[67] Public health, he believed, was the application of the science of preventive medicine through government for social ends. It was designed specifically to serve social needs rather than personal ends and, as such, excluded from its purview, care of the sick. Furthermore, to add medical care to the role of the health officer would dilute and divert "the best" that had been achieved in public health service. Emerson's judgment was that only clinicians should be entrusted with the diagnosis and treatment of the sick and with preventive services to individual patients.[68] APHA, he believed, was at the "crossroads." A decision would have to be made whether "professional distinction and special usefulness" would be maintained or whether the Association would become "a general utility agent for social theorists and legislative utopians." He concluded with an appeal for a rededication of the time-honored mission of the Association to make "health protection and health creation" a permanent and exclusive objective.[69]

Joseph Mountin, who had served with Emerson on CAP since 1931 and who had been a member of the Technical Committee on Medical Care, could not have disagreed more with Emerson's interpretation. Emerson had been especially fearful of federal legislation drafting public health workers for duties for which they were untrained. This matter of administrative responsibility for public medical service, Mountin believed, deserved serious consideration, for on that principle would hinge the future welfare of the public health profession.[70]

Mountin espoused the position that the inherent opportunities for enlarged health services to the community far outweighed whatever disadvantage Emerson might have mentioned. With such expansion the health officer could exploit all the possibilities of health promotion. Prevention would continue to be his primary concern, but a second objective could be to restore and rehabilitate those unfortunate individuals on whom sickness fell. These purposes could be more easily accomplished, he reasoned, if the health officer had at his command techniques and facilities for performing service suited to the individual's requirements than under the present dispersion of authority.[71]

Mountin gave examples where preventive and curative medicine had been merged and noted forcefully that the "old dodge" that the health officers' main function was to prevent, not to cure, was no longer acceptable. He concluded his paper with the hope that the Association would choose to enter the dialogue and not remain silent. If the Association said nothing, he cautioned, it was entirely possible that a program would be developed for them by political leaders.[72]

Yet Emerson and Mountin had only obliquely touched on the problem. There was another more fundamental issue than traditional versus dynamic public health. In an exchange of letters between Michael Davis and Emerson, and C.-E.A. Winslow and Emerson,[73] it is evident that the principles set forth in the Wagner Bill had reached the inner core of their beliefs. Phrases such as "social fanaticism," "emotional outbursts not being worthy of your qualities," "objective facts versus hypothetical possibilities," and "I can hardly believe my senses," punctuate the correspondence and reveal the irreconcilability of their opinions. It was of course more than simply the Wagner Bill that was at stake; rather it was what the Wagner Bill and the New Deal stood for.

Emerson in 1939, for example, had presented the Trimble Lecture to the Medical and Chirurgical Society of Maryland and the lecture subsequently had been published in Gannett's *America's Future*. Davis was dismayed that Emerson "had chosen to ally himself" with such a cause as the National Committee to Uphold Constitutional Government. "Surely you are not in sympathy with the political and economic objectives of this group?" exclaimed Davis. Emerson replied that it was not worth the effort to discuss his entire life, but that he was certain of one thing:

> . . . namely, that the direction of those people who are backing the Wagner Bill and similar proposals for extension of Federal jurisdiction and monetary control over state and local medical services are damaging both the social and economic principles which appear to me indispensable for an orderly and representative free society, based on the initiative of the individual and local government rather than the dominance of the federal government . . . [M]ost of the policies proposed by the New Deal and prompted by the group which has interested itself in the Interdepartmental . . . and Technical [Committees] are unwise and will damage rather than help the National Health. I have lost faith that I once had in the competence, disinterestedness and leadership of those who have appeared to speak for economics and sociology. Step after step, for the last seven or eight years I have found it impossible for me to continue with any conscience or confidence to follow the direction into which many of my long time associates have believed it best to go.[74]

The Forties

In early 1940, Reginald Atwater, Executive Secretary of APHA, asked Michael Davis to comment on the activities of his Subcommittee on Organized Care of the Sick during the late twenties and early thirties. Davis revealed

his frustration with CAP when attempting to develop policies or standards in cooperation with hospitals or welfare bodies. Such difficulties he ascribed to "differences of opinion" within CAP as to whether medical care was within its scope at all. He was critical on another account as well. CAP, he charged, had conducted countless field surveys but had been incapable of acting on the results of its own surveys; nor had it critically reviewed methods of effecting change. To study and improve relations of public health work to medical care, Davis concluded, did not and had never required a "dogmatic attitude" as to the scope of public health; it did, however, require "an open-minded experimental attitude."[75]

The Subcommittee on Medical Care, 1940-1944

Prompted by the changing times to recognize its need to express itself on matters of medical care, CAP met in New York City to consider its alternatives. Dr. Joseph Mountin, then Assistant Surgeon General and formerly chairman of the CAP Subcommittee on Current Health Department Practices, and who earlier had been invited to prepare a document outlining a potential role for a reorganized Subcommittee on the Organized Care of the Sick, was the principal speaker. In his presentation, Mountin considered a number of possible activities for such a Subcommittee, including selected studies and demonstration projects, the development of standards, formulation of policies, and a collaborative role with other health, welfare, and medical agencies. Throughout his discussion he spoke of the maturation and dynamism of the public health profession. In the past, public health had been only remotely concerned with the need to care for the sick. Devoting most of its time to environmental sanitation, communicable disease control and health education, the profession had believed that the separation between official prophylaxis and private therapeusis was in its own best interest. Yet, as Winslow and others had maintained,[76] there were very few substantive differences between measures to promote, conserve, or restore public health. From the standpoint of good administration they were really inseparable. How strange, he concluded, that the lay public had appreciated this point in advance of the professional groups concerned primarily with the technical aspects of their particular interests.[77]

The program that Mountin had proposed for the Subcommittee, and which had been approved by the CAP in 1940, encompassed the following categories: Preparation of bibliographies and digests of available data relating to incidence of illness and the content and costs of medical service; preparation of articles describing the experience of health departments having responsibilities for the administration of medical care programs; development of survey techniques and of criteria of adequacy in respect to public medical care programs; and detailed examination of existing programs. The Subcommittee, then, was to be concerned essentially with studies designed to throw further light on problems relating to medical care and the role of the health department in the administration of service programs.

Between 1941 and 1943, the Subcommittee fulfilled many of the objectives which had been outlined by Mountin. Indeed, the pursuit of survey data and design of appraisal forms and questionnaires was a continuation of the tasks which Davis had developed for the Subcommittee in the twenties and thirties. In 1941, for example, it was recommended that a survey be made of medical facilities operated by health departments. According to this plan, questionnaires would be sent to all health departments on the Health Conservation Contest List. A follow-up interview schedule would then have been administered by the CAP field staff to health officers of those health departments determined to have varying degrees of responsibility for medical services and which provided services under varying administrative arrangements. The objective of the study was to develop a "community picture" of both public and private agencies concerned with health and their mutual relationships.[78]

Other topics were discussed by the Subcommittee, such as the surprisingly large number of men rejected by the Selective Service Commission. It was believed that the public health profession, as well as the medical profession, had failed to reach these rejectees. To determine how best these men could be rehabilitated became one of the Subcommittee's objectives. The American Red Cross already had set aside some funds for experimental rehabilitation programs but no one had yet resolved the problem of how those who were not indigent could be treated; nor had anyone yet studied the legality of obtaining from local draft boards the names of those men rejected for service owing to medical disability.[79]

It was perhaps these considerations, plus the expanding Congressional concern about personal health services, which had prompted Mountin in the fall of 1943 to explore the possibility of expanding further the scope of the Subcommittee so as to cover the field of post-war planning in public health. He intended to expand the membership to include individuals working in the field who would have access to data which would be of immediate use to the Subcommittee. A small group of such individuals—I. S. Falk, E. F. Daily, and G. St. J. Perrott—already had met with Mountin in Washington and ultimately had concluded that the Subcommittee could serve several useful purposes. For example, the Subcommittee conceivably could analyze the effect which medical care problems had on the general public health; it might formulate "a reasonable attitude" for public health agencies to assume toward medical care and develop "suggestions" as to how public health agencies might participate in medical care problems; and, in general, it could represent APHA at meetings of committees appointed by related associations to consider medical and allied questions.[80]

Reginald Atwater believed the idea to expand the Subcommittee's scope along these lines was "highly desirable." He also advocated, as had Mountin, a new title for the Subcommittee. Mountin earlier had suggested "Subcommittee on Post-War Medical Service Practice," which Atwater acknowledged as having the "advantages of brevity" although failing to reveal the intended scope. Atwater's first choice was "Subcommittee on Post-War Health Department Participation in Medical Services."[81] Each recommendation was precise but seemed not to reflect the real intention of Mountin's concept of the changing times. Then why not "Subcommittee on Medical Care?" Medical care, after all, was a legitimate consideration of the federal government. The phrase which had been submerged in the thirties had crept into common usage. There were proposals

for hospital and medical care insurance; there already existed a quarterly journal with the title *Medical Care;* medical care and medical economics courses were being offered in schools of public health; and APHA's own report, "Desirable Minimum Functions and Suitable Organization of Health Activities," already had made reference to medical care and the health department.[82] It was now necessary to speak in broader terms. The Subcommittee's original proposals, which Mountin believed should include the effect of medical problems on general health and the determination of the role of public health in medical care, and which had been approved by the APHA Executive Board, represents, then, a continuation of the development toward a more dynamic interpretation of the public health field.

Thus, the name was changed to respond to this increasing awareness that health agencies, such as APHA, should "confront" medical care issues rather than "dodge" them, which was also why Mountin had given his Subcommittee the charge to keep abreast of the changing aspects of medical care, stimulate an interest on the part of health officials in medical care problems, and determine how health agencies might participate advantageously in medical care programs.[83]

The objectives and philosophy of the proposed Subcommittee on Medical Care were formally expressed at a meeting held in Ann Arbor in January, 1944.[84] In attendance were Mountin, chairman of the existing but not yet legally reconstituted Subcommittee; Henry Vaughan, chairman of the parent Committee on Administrative Practice; Graham Davis of the Kellogg Foundation; and Reginald Atwater, Carl Buck, and George Palmer of APHA.

After a preliminary discussion of CAP's earlier Subcommittee on Organized Care of the Sick and the committee which had been revitalized in 1939-40, a proposal was made that the CAP chairman establish a Subcommittee on Medical Care and include, besides Mountin as chairman, Nathan Sinai, Graham Davis, George Perrott, Alan Gregg, I. S. Falk, Edward Daily, Emory Morris, J. R. Hege, E. S. Rogers, D. D. Carr, Katherine Faville, and Earl Brown. Each member proposed had broad experience with medical care subjects, in academia, philanthropic foundations, or at various governmental levels. Sinai, for example, was Professor of Public Health at the University of Michigan; Daily, Falk, and Perrott worked for the federal government; Brown, Hege and Rogers were health officers; Morris and Davis were associated with the Kellogg Foundation; and Faville with the War Nursing Board.

At this first meeting, Atwater asked the crucial and revealing question whether the new Subcommittee was to be regarded as a "study committee" or as a "policy-forming group with some propaganda purpose?" The question was important for various reasons. If the Subcommittee was merely to collect data, then many who had been asked to serve would decline the offer. Falk, Director of the Bureau of Research and Statistics of the Social Security Board, for example, hesitated to participate on a Subcommittee that might fail to take a more "aggressive position" with respect to medical care.[85] Mountin spoke to this hesitancy by assuring Falk, and others who had been asked to join, that the Subcommittee would consider all aspects of medical care, including "the formulation of policy." With such a charge, Mountin believed that the Subcommittee had "the unusual opportunity to go forward under much more favorable auspices than had ever been possible heretofore."[86] Mountin also expressed the hope that the Subcommittee would "represent" APHA and, to effect this purpose, believed that the Subcommittee should concern itself with the formulation of an "attitude" for the Association. To accomplish this task the Subcommittee decided that it should immediately seek to establish relations with existing health agencies; translate and interpret the studies and plans of these agencies for APHA and local health officers; stimulate and encourage an intelligent interest in medical problems and plans; and formulate the functions of health officers to future plans and programs of medical care.[87]

By the next meeting, however, the tone and direction of the Subcommittee's objectives had changed. Members of the Subcommittee—after a brief consideration of specific topics such as, a need for a definite plan to reach organized medicine and a program of strategy to bring that plan into being, and the advantages in having a hospital, doctors' offices, and public health department in the same building—arrived at the consensus that the purpose of the Subcommittee on Medical Care should be:

1. To develop the outlines of a national medical care program, and to define the role of the health department in relation to such a program;
2. To formulate policy for APHA with respect to this matter; and
3. To develop a plan for action by APHA to bring about the development of an inclusive type of program as an essential step toward improvement of national health.[88]

After this meeting, Atwater wrote a letter to Abel Wolman, Chairman of the APHA Governing Council, in which he described the composition and goals of the newly reconstituted Subcommittee.[89] The letter reveals the important role played by Atwater who emerges in this early period as the young Subcommittee's benefactor. The members of the Subcommittee, he wrote, were "close to the very dynamic areas of medical need." Many were health officers who themselves administered public medical services. The cross-section indicated a "forward looking philosophy" in the area of medical care, "but [one] strongly influenced by contact with reality." Atwater further added the observation that thousands of APHA members had expressed very "conservative" views on medical care subjects and, for this reason, the Subcommittee had been "weighted on the liberal side." The balance had been arranged, he noted, so that the Subcommittee could achieve a reasonable definition of APHA policy for review by CAP and the Executive Board.

Atwater concluded his letter to Wolman with a list of observations about the new Subcommittee and its proposed programs. His list, which had been reviewed by Louis Dublin, is indicative of the Executive Board's interest in meeting its obligation to change; it also indicated the necessity of keeping the report within the scope of APHA's own goals and objectives. Atwater wrote approvingly of the Subcommittee's goal to consider medical care in a national program. The APHA needed a statement of policy "closely related to reality." Earlier statements, which had been approved by the Association in 1938, 1941, 1942, and 1943, were regarded by Atwater as "pious." Therefore, he supported the composition of the Subcommiteee as "repre-

sentative of liberal opinion," which he believed would deliver a report with "a cutting edge." He assured Wolman that the Association as a whole had little to fear "considering the make-up of CAP and the Executive Board; the Executive Board [furthermore] can completely control the result of [the Subcommittee on Medical Care's] deliberation and can take or leave what comes out."[90] APHA was very soon confronted with just such a choice.

Medical Care in a National Health Program

Some 4,000 members and fellows of APHA assembled in New York City for the 73rd Annual Meeting, planned in connection with the Second Wartime Public Health Conference. It was the year that John Sippy of California had become president and Milton J. Rosenau, referred to as the "Dean of Public Health in the United States," president-elect. Although the program included many papers which predictably considered war-related topics—the control of typhus with DDT; venereal disease epidemiology in wartime; and "a new disease of the war," infectious hepatitis—and others were concerned with subjects characteristic of traditional public health, the "most outstanding problem" discussed at the Annual Meeting, according to Winslow, was that of medical care. "For over twenty years, the topic of medical care had been avoided," wrote Winslow commenting on this meeting for the *American Journal of Public Health*, "but at last, in 1944, it was faced with courage and determination."[91]

The papers on medical care were to be delivered at a special session that had been planned months earlier by APHA Executive Secretary Reginald Atwater and Joseph Mountin.[92] For the new Subcommittee, the special session was an opportunity to subject its ideas on medical care in a national health program, which had been its principal concern for over eight months, to the scrutiny of the Association.

The subject had been raised first in February 1944 when the Subcommittee chose to "spearhead" the movement for a national health care program and decided to develop the outlines of such a program and define the role of the health department in relation to such a program as its first charge.[93]

The principles agreed upon at its first meeting, and at subsequent meetings, were based on a series of memoranda submitted by an ad hoc committee comprised of Falk, Rogers, Sinai, and Daily.[94] The ad hoc committee first considered six aspects of the program and one statement of principle; namely, "that essential health services should be available to all, irrespective of the individual's ability to pay for care." The committee considered financing (by compulsory insurance or general revenues); benefits (all essential services); administration (federal, state, and local participation); remuneration of physicians (by salary or fee-for-service, the former the most preferable, the latter least); existing insurance organizations (to be utilized in the program only in so far as their participation would promote effective, efficient, and economical administration); and construction of health facilities (related but secondary to financing). In April and June[95] the program was further refined and a preliminary report, completed in June, submitted to the Executive Board and to Wilton Halverson, chairman of the CAP. The draft was published in the September number of the *AJPH* and soon became the subject of a heated controversy, judiciously kept within the bounds of the Association, and paralleling the contemporary reservations about health legislation and the emerging role of a "new" public health.

The Preliminary Report of the Subcommittee[96] considered objectives of and needs for a national health program and recommendations for immediate action. The objectives, stated in abstract form, were that a national program make available to everyone, regardless of ability to pay, all essential preventive, diagnostic, and curative services, insure high quality and include the constant evaluation of practices and extension of scientific knowledge. The needs were those which had been reiterated in countless medical-economic surveys; namely, that large numbers of the population received insufficient and inadequate medical care, because many could not pay or because services were unavailable; that there were extensive deficiencies in physical facilities, in the number and distribution of personnel needed to provide services, in the number and categories of personnel qualified to administer facilities and services, and that such deficiencies were greater in poor communities; that many communities were not served by public health departments; and that expansion of scientific research was urgently needed, for "despite past and current scientific advances, knowledge as to the prevention, control, or cure of disease is lacking."

Eight recommendations appear in the report as "guides to the formulation of a policy for action," subject to later study and refinement. The first three recommendations concerned service, financing, and organization and administration of the services. The aim of a national plan, as outlined in the first recommendation, was to provide comprehensive services[97] for all the people in all areas of the country. The goal admittedly was long-ranged, one not to be attained for ten years, but could be implemented in stages and extended and accelerated as time went by. A crucial feature of the first recommendation was that "the plan include and emphasize the provision of preventive services for the whole population."[98]

Services were to be financed through social insurance supplemented by general taxation, or by general taxation alone, and the role of the federal government was "to equalize the burdens of cost in accordance with ability to pay." The report advanced the principle that a single responsible agency was a requisite to effective administration at all levels of government and that public health agencies should carry the major responsibilities in administering the health services of the future. It was believed that public health agencies, "because of administrative experience and accustomed responsibility for a public trust," were uniquely suited to assume larger responsibilities, but that they should begin immediate training programs for both themselves and their staffs. The authorized agency responsible for administration was to have the "advice and counsel of a body representing the professions, other sources of services and the recipients of service." Private practitioners in each local administrative area were to be paid according to the method they themselves would choose; i.e., fee-for-service, capitation, salary, or combination of these. None was considered perfect, but attention was drawn to the fact that fee-for-service had an unsatisfactory history.

Recommendations also included construction and

modernizing of hospitals, health centers, and related facilities, made possible by funds from the federal government on a variable matching basis in accordance with the economic status of each state. Funds were to be granted only if state agencies, preferably state health departments, had surveyed the needs of the state for health facilities and had designed a master plan for the development of the needed facilities.

The fifth recommendation, "Coordination and Organization of Official Health Agencies," took notice of the fact that there were too many disparate health agencies competing for the health dollar and that studies and conferences should be undertaken in states where the health structure was found to be unnecessarily complex.

The final three recommendations pertained to training and distribution of service personnel (financial assistance provided by the government for continuing education and for developing more health auxiliaries, some of whom should be encouraged to practice in rural areas); education and training of administrative personnel (to serve as administrators of the medical care program, for hospital and health center administrators, and for nursing supervisors); and expansion of research (made possible by grants from various federal agencies to profit institutions for the support of laboratory, clinical, and administrative studies and demonstrations).

The plan was comprehensive and pragmatic. Parts, of course, had appeared in previous medical-economic surveys and in past and current health bills, but Hugh Leavell,[99] the Executive Board liaison to the Subcommittee on Medical Care and a supporter of the principles and recommendations found therein, believed that the Subcommittee had been innovative, and that nowhere in the statement could one find the use of "weasel words." Rather, the report expressed what the Subcommittee felt APHA should say on the subject of medical care.[100]

Criticism of the Subcommittee's Report

The preliminary report of the Subcommittee had been submitted by Mountin to the Executive Board and CAP chairman Wilton Halverson, then California State Director of Public Health. Mountin was desirous of having the statement brought up before CAP for discussion. If approved by CAP, it would then be submitted to the APHA Governing Council, where Mountin believed the chances were good for it to be approved as a policy statement of the Association.

Upon receipt of the report, Halverson sent a copy to Haven Emerson, vice-chairman of CAP, with the request that he comment on the substance of the report. He also pointed out that it was scheduled to appear in the September number of the *AJPH* because, "on controversial questions of this kind, it is important that all of the membership have the opportunity of expressing themselves on the matter."[101] Emerson replied by return mail, obviously perturbed by the entire affair. He believed that it would have been "wiser and fairer" to CAP if the Subcommittee had discussed the matter before it appeared in print. It would be difficult, he believed, to consider the report "objectively and impersonally" since the published statement would obviously generate a great deal of controversy. Moreover, the members of the Subcommittee

> . . . are so wedded to . . . the Murray-Wagner-Dingell bill, and so closely concerned as salaried officers of the federal government with the promotion of the ideas of the Social Security Board and . . . who wish to revolutionize the entire basis of medical practice, that I see in this urge for prior publication a rather slick move to convince the members of the APHA to support the report.[102]

Emerson disagreed with the basic assumptions of the statement, which he believed were of an economic, sociologic, and professional character. The proposals he dismissed as mere "rephrasing of the ideologies of the original Wagner bill without substantial experience or professional support." There was "no body of professional workers in the sciences or liberal professions who have endorsed the principles or the programs set forth in the report" and he did not wish APHA to be the first to do so. He continued his effusion with sentiments he had expressed before; namely, that "the Association was not qualified to declare upon such national policies as care of the sick." As to the Subcommittee members, "[they were] so wholly inexperienced in all really important phases of diagnosis and treatment of disease in the individual as to disqualify them for leadership in this matter." He tossed off the report as nothing more than "another effort on the part of partisans of the federal administration to push the APHA onto the bandwagon of social control and direction of physician's services." Hoping that Halverson would convey his misgivings and recognize the "political implications" of the report, he concluded his letter with the request that CAP and the Governing Council disapprove the report as "not representative of the opinion and objectives of the APHA."[103]

Halverson replied that he was sure that those concerned "would be alive to the political implications" and that Emerson should not be too worried because the total membership of CAP was a "fairly competent cross-section and a group not likely to be very far out of line in its total thinking."[104] To Atwater, however, Halverson expressed concern. How, he wrote, should the statement of the Subcommittee on Medical Care be handled if there were others who had as vigorous reaction to it as had Emerson?[105] Atwater responded that the decision to publish the report conformed with an established Association routine that important reports should have wide circulation in preliminary form before they were adopted. With respect to a strategy, Atwater believed that so "controversial an issue ought to be handled with complete objectivity." No matter what the principal parties feel about the report, he wrote, the statement must have a "fair hearing" and exemplify "the democratic process."[106]

Atwater also chose to answer Emerson's charges about the Subcommittee. He noted that some of the members of the Subcommittee had been involved with the National Health Conference of 1938 and its subsequent studies and legislation. To his thinking, this fact should not prejudice their sincerity or right to be heard. He disagreed with Emerson's contention that the members of the Subcommittee on Medical Care were wholly inexperienced. "If [Emerson] were quite objective," he wrote, "he would have to recognize the fact that at least six physicians identified with the Subcommittee are themselves actively engaged in the diagnosis and treatment of disease and the administration of public medical services." Indeed, he added, such points had been kept carefully in mind when the Subcom-

mittee originally had been constituted by Drs. Vaughan, Mountin and Atwater himself. Attempting to reassure Halverson further, Atwater concluded that "wise statements will come out of the crucible of open consideration and frank statements by those with intelligence and good will."[107]

One week later, Atwater mailed a letter to each CAP member informing them of Halverson's and his decision, made "in accordance with APHA policy," that the report was to appear in preliminary form in the September issue of the *AJPH* "with the thought that this action would contribute to its consideration and make it more readily possible for the Association to take judicial action, perhaps at its forthcoming meeting."[108]

The report was indeed discussed—as the first order of business—at the October 1, 1944 CAP meeting. Haven Emerson, vice chairman of CAP, presiding in the place of Wilton Halverson who was not present owing to an accident, recommended different wording, but was less emphatic in his criticism than he had been in his letter to Halverson. Except for minor editorial changes and an additional concluding paragraph,[109] the report remained intact and was "endorsed in principle" by CAP. The Committee further voted to transmit the report to the Governing Council with the request that it be favorably considered as a statement expressing the position of the Association in respect to the role of medical care in a national health program."[110]

The Governing Council discussed the CAP-approved statement at its first meeting on Monday, October 2nd, but held it over for 48 hours to permit "full consideration." On Wednesday, October 4th, at 2:30 P.M.—oddly at the same time that representative speakers of the Subcommittee on Medical Care were presenting papers on selected aspects of the report at their Special Session—the Council deliberated the merits of the Subcommittee's statement. Mountin, rushing from one session to another, spoke first, enumerated the editorial changes proposed by CAP and noted the desirability of APHA taking a stand on medical care. Others spoke to the inappropriateness of the statement itself; the radical nature of the recommendations; and the fact that medical care was not a legitimate concern of the Association. An amendment was then introduced by Walter L. Bierring, M.D., which "thanked" the Subcommittee on Medical Care for its report, and directed a special APHA committee (but not the Subcommittee on Medical Care) to meet with representatives of AMA and the American Dental Association to prepare a report on a nationwide plan for medical care. The amendment further directed the three groups to issue a joint statement which was to be published in the *AJPH* and subsequently presented to the Governing Council at the next annual meeting in 1945. After a lengthy debate the amendment was disapproved by a vote of 39 to 17 and shortly thereafter the Council voted to approve the report as an "official statement" of the Association by a vote of 49 in favor, 14 against.[111]

There were those who were jubilant about the Governing Council's favorable vote; others were thoroughly dissatisfied and deeply concerned that the Association had moved too quickly and precipitously. Wilson Smillie, Professor of Public Health at Cornell and a Fellow of the APHA, for example, prepared a critique of the program, to which he gave the informative subtitle, "After Ample Opportunity to Study the Proposals."[112] He believed that the Subcommittee report represented a "revolution in nationwide social policy," whose implications would reach deeply "into the very foundations" of national life; indeed "every mode of life of every living person in the nation" would be materially affected.[113] For these reasons, Smillie set about the task of reexamining the elements and implications of the program.

Smillie interpreted the plan to be a comprehensive, compulsory program for complete medical care in all its aspects for all the people of the United States. Provision for medical care throughout the nation was to be organized and administered by a central agency of the federal government. The "administrative machinery," he wrote, was to "extend down through the social fabric, through the states, to counties, to large municipalities, to towns, to villages, and out into the rural areas, throughout the whole nation." Financing for the program was to be by a central source of funds to be collected by "compulsory contributions," and "its administration [was to be] imposed upon all the people, quite irrespective of local community opinion or desire."[114]

His first major criticism was with regard to administration and excessive federal controls. Smillie was concerned that there would be no local autonomy, "no outlet for initiative, no chance for expression of local opinion as to local needs, no opportunity to formulate local policies." Such a program of administration, "that extends its tentacles from the central government . . . until it invades the homes of every private citizen," might be called a bureaucracy, as it was in European governments, but in the United States, he wrote, no one should forget that "the principle of local self-government is the very core of our national strength."[115]

The program approved by APHA, according to Smillie, did not build local autonomy and local community participation into its structure; rather it proposed to create a "single, central administrative body." The issue, however, was palpably confusing. Mountin, in his "Brief," had recognized "the desirability of decentralized operations with participation by state and local authorities," but also had stated that "an unrelated series of state and local plans cannot assume a suitable service [which is] national in scope." In Smillie's opinion, the program provided for decentralized administration but did not provide for local autonomy. Rather it incorporated "local self-government under federal jurisdiction."[116] There would be no autonomy, he wrote, if the local community had no responsibility for financing the program, no direct control of budgetary allotments, and no voice in determining broad general policy.[117] Such a program envisioned by the Subcommittee, Smillie believed, would not be "a stimulation of local self-government, but engulfment." It would not be independence, but elimination of local community initiative and local responsibility.

His summary contained fewer emotional words and phrases than appeared throughout his critique but he did reiterate his major concern that the program would provide for

> an enormous central federal administrative agency which [would] impose upon the whole American people a program of compulsory, contributory medical care which will encompass all facilities for public health, preventive medicine, epidemiology, industrial hygiene, child health

> protection, together with all phases of hospital care, physicians' care, nursing care, convalescent home care, rehabilitation, care of chronic illness, and a thousand other details relating to medical care and to public health and public welfare. All this is provided for, without consideration for the fundamental principles of local self-government, wherein lies the elementary strength and basic power of our American mode of life.[118]

Smillie reemphasized his belief that it would have been more appropriate, in planning for the development of a nationwide program for medical care, to have utilized

> the genius of the American people for local self-government, to employ the enormous latent forces of voluntary cooperative enterprise, to develop a medical care program slowly and progressively on a local community basis, building on the sound foundation of local community autonomy, with state guidance, and with state assistance when necessary; and with federal encouragement by subsidy to those communities in greatest need.[119]

The Subcommittee on Medical Care's statement on Medical Care in a National Health Program was merely the first of three documents devoted to medical care that appeared in 1944. Smillie's criticism notwithstanding, the Association continued to study carefully additional contributions toward the solution of complex medical care issues.[120] The first was a report on the "Principles of a Nation-Wide Health Program" prepared by a Health Program Conference sponsored by Michael Davis' Committee on Research in Medical Economics.[121] The purpose of the Conference was to formulate the elements of a nationwide program which would unite the views of physicians, economists, and officers of government agencies concerned with medical care.[122] The report of the Conference stressed that good medical care was a necessity of life, comfort, and efficiency; that the need of medical care had been insufficiently met for a large number of persons and that to meet the need, public action would be required on a nationwide scale. Its program had been established on the general aim that good medical care—preventive, diagnostic, and curative—was to be made available to all people in proportion to their need for it and regardless of their ability to pay and, additionally, rested on ten recognized principles of medical care.[123]

The second report was the product of a Conference called by the Physician's Forum for a study of medical care problems. At this meeting medical care issues were discussed by progressive physicians with 150 representatives of consumer groups. It was the first conference of this type and scope since the National Health Conference of 1938. At the Conference, organized medicine was criticized by Ernst Boas of the Physician's Forum for its isolationist attitude; Dr. Henry Richardson of Cornell stressed the need for better distribution of hospitalization facilities and the reorganization of already existing hospital beds; Dr. Franz Goldmann of Yale, reviewing the various methods of paying for medical care, pointed out that the problem was now not whether a larger share of the national income was to pay for medical care, but whether methods of organization that systematized existing expenditures and insured the most effective utilization of available resources should be adopted; Dr. Channing Frothingham of Boston, Chairman of the Committee of Physicians for the Improvement of Medical Care, discussed four basic factors necessary to obtain good medical care—well-trained physicians, essential equipment, sufficient nursing service, and appropriate supplies for medication, both preventive and curative; and Dr. Alan Gregg of the Rockefeller Foundation stressed research as fundamental to the development of good medical care programs.[124]

All three programs, the Subcommittee's Statement, the Health Program, and the Physician's Forum, differed in their emphasis on detail; but they were identical in their delineation of future trends.[125] The measures that each program brought forward—including provision for essential preventive services and facilities, for protection of the quality of medical care and for the definition of responsibilities of administration—were considered "essential" ingredients of any federal legislation. By the end of 1944, then, the Association had recognized that the question before the American people with regard to the provision of adequate medical care was no longer "Whether" but "How."[126]

The Subcommittee on Medical Care, 1945-1947

In 1945 the Subcommittee set about the task of seeking funds for its future activities. When it was learned that the Rockefeller Foundation was interested in the objectives of the Subcommittee,[127] a memorandum was drafted in which its aims and purposes and future goals were expressed.[128] The memorandum noted that the Subcommittee intended to play a leading role in the development of a program to bring adequate health care to the American people and, because of its composition, was peculiarly fitted to give responsible "technical direction" to the movement and, accordingly, would take the lead in presenting to the public, the profession, and government its ideas as to the nature and design of a suitable health program.

The Subcommittee expressed its concern that the current drafting of legislation had been undertaken without the benefit of consultation with its members. Since there was a manifest need for consecutive planning by those familiar with community organization for health and medical services, and since this "special quality" was one for which the members of the Subcommittee had been selected, the Subcommittee believed it should be involved in the vital area of health policy if it had sufficient funds.[129] Specific aims also accompanied the memorandum. The Subcommittee, for example, proposed to refine the specifications for a suitable medical care program; to evaluate the experience of existing medical care programs and lay the basis of factual knowledge necessary for solution to the problem; to review proposed federal and state health legislation in the light of declared principles and further recommend to APHA a stand which may be taken on such legislation; and seek to aid in informing public health personnel as to medical care problems and to stimulate the assumption of leadership in the formulation and administration of medical care programs.[130]

While awaiting disposition on its request for funds the Subcommittee proceeded on an ambitious program of studies. Members were asked, for example, to study various voluntary, municipal, veterans' and mental hospitals; analyze programs for mental health and chronic diseases, school health, and nursing services; and compare service with cash indemnity contracts. Additionally, the Subcommittee reviewed pending legislation including the revised

Wagner-Murray-Dingell bill (S. 1606) introduced in November, 1945.

The Subcommittee request for $20,000 was approved in 1946 by the Rockefeller Foundation and immediately thereafter Howard Kline (Technical Secretary), Milton Terris (Medical Associate) and Cozette Hapney (Research Associate) were hired to carry on the day-to-day operations of the Subcommittee. The tasks of the technical staff were rather broad and deserve mention. The staff was responsible for collecting papers, documents, and materials on various aspects of medical care and collateral problems; for keeping the members of the Subcommittee informed on recent planning, legislative, research, and program developments by maintaining a flow of informational material on bills, hearings, official reports, and speeches; for preparing questionnaires on the volume and character of medical care services rendered by full-time local health departments; for evaluating special programs for the provision of medical care for needy persons; and for seeking to establish joint endeavors with related agencies such as the American Public Welfare Association and the American Hospital Association.[131]

In June 1946 the Subcommittee considered a proposal submitted by its "Washington Sub-Subcommittee [sic]" calling for an Addendum to the Subcommittee's statement of 1944. The proposed Addendum, completed in September,[132] took note of the fact that the planning and development of patterns and programs for improved national health generally had been consistent with its recommendations, but that the statement had not provided answers to all of the problems posed by a comprehensive national health program. No statement could be expected to provide all the answers, but the Addendum specifically was to facilitate better understanding and application of the original, Association-approved policy statement.

The Addendum represented, then, a reaffirmation of its earlier principles and went further—to oppose, for example, the segregation of the medically needy from the rest of society; to request that Congress formulate a national health plan that was both comprehensive and flexible, in terms of administration, methods of financing, and the timing of program inauguration and expansion; and additionally to recommend that health departments assume an active and progressive role in the development of medical care programs; that gaps be filled and overlapping programs be avoided; and that the program be administered by a single health agency at each level of government.

The Addendum actually offered only one innovation—that related to the medically indigent—and was a rather poorly written and repetitive document. If compared with the original statement, there is not very much that is different despite the many allusions to the fact that the original statement needed adaptation, strengthening, or expansion. And yet the Addendum, when brought up before CAP at its meeting in Ann Arbor, was tabled. The motion to table sent a shudder through the Subcommittee members who attended that meeting and set them to wondering if that motion had signified the imminent dissolution of the Subcommittee by the parent CAP.[133]

Vlado Getting, a recent addition to the Subcommittee and additionally, Secretary-Treasurer of the Association of State and Territorial Health Officers, for example, believed that the essence of the Subcommittee report and the Addendum had been that APHA take a positive role in advancing health legislation; have representatives at hearings in Washington; help draft health legislation; and speak for the Association on medical care matters. He noted that as a result of the motion to table the Addendum, the Subcommittee did not know what its "mandate was for future action."[134]

Wilton Halverson, chairman of CAP, responded to Getting's query. He noted that it was "unfortunate" that the discussion of the Addendum had not continued, but firmly believed that the motion signified no premeditated policy of restraint on the part of CAP. Moreover, CAP had accepted the Subcommittee's report, voted to approve its continuance and additionally requested the Subcommittee "to direct its major activities in the year ahead to the clarification of definition as to what a National Health Program means [and] to the development of a definition of what should be included in good medical care and to the collection of facts upon which some method of evaluation of the need and the means of meeting the need can be based."

Halverson also took issue with the policy of having representatives of APHA present statements before legislative committees on health legislation introduced in Congress. If the Association, however, did decide to present its position, that decision would be made by the Executive Board and not CAP or its Subcommittee on Medical Care, which after all were both "study committees."[135]

The Subcommittee on Medical Care, now assisted by yearly grants from the Rockefeller Foundation and an energetic and capable technical staff, appeared unconcerned about CAP's decision to table the Addendum. There was much else that had to be done. In 1947, for example, a joint committee comprised of representatives of the Subcommittee, AMA, AHA, and American Public Welfare Association, issued a comprehensive report, "Planning for the Chronically Ill," which encompassed the epidemiology of chronic illness, prevention, research, medical treatment, home, hospital and nursing care, convalescence and rehabilitation, and a call for cooperation and coordination of voluntary services.[136] In the same year, there had been a joint APHA-AHA committee to study hospital-health department relationships;[137] a study group on voluntary medical care plans, a second on methods of improving the quality of medical care services, and a third joint study group on federal-state-local relationships in medical care programs, comprised of two subcommittees of CAP, on Medical Care and on State and Local Health Administration. The Technical staff additionally had begun its involvement with a number of research studies including an analysis of the experience of the Maryland Medical Care Program,[138] various administrative patterns for improving the quality of care, joint housing of hospitals and health departments, and health department administration of medical care services.

Toward the end of 1947, Howard Kline received, through Edwin Daily of the Children's Bureau, a request from Dr. Martha Eliot, director of the Bureau and APHA president-elect, for information pertaining to the Subcommittee's present status and scope of activities. Kline believed that Dr. Eliot's request indicated that she had been giving thought to the idea that the Subcommittee be made a permanent, full Committee of APHA.[139] The request by Dr. Eliot actually had been prompted by two sources.

That there were misgivings about the future of the

Subcommittee on Medical Care if it were to be continued indefinitely as a CAP Subcommittee already has been noted. Strains had certainly developed, owing in no small part to the inherently broader field of the Subcommittee than of its parent Committee. What then of the possibility of converting the Subcommittee into an independent committee? In a letter to Reginald Atwater,[140] I. S. Falk expressed just this point one year prior to Eliot's request. Falk had noted the "anomalous relation between the fields" of the Subcommittee and CAP. Citing from the proposed bylaws of the Association, with regard to the functions of CAP (Article X, Section 4,b), Falk noted the prescription that CAP "shall engage in the collection of information regarding current health practices and analyze the material obtained to derive standards of organization and achievement." In Falk's mind, the framework of CAP simply was not broad enough for the work which the Subcommittee was, from its inception, intended to do. Additionally citing the tabled Addendum, Falk expressed the belief that it was apparent that "the cramped quarters" in which the Subcommittee had found itself would make it impossible for it to carry on its future activities. Falk therefore recommended the creation of a new Committee on Medical Care, or perhaps on a National Health Program, or on National Health Services, or some such similar title. With his usual forethought, Falk further noted the advisability of establishing this proposed Committee first as a "special" committee, to serve for one year and feel its way.

Falk's letter, which had been written as a personal suggestion, involving in no way the Subcommittee or its chairman, was answered by Atwater immediately. Atwater believed that if Falk's proposal were brought to the Committee on Constitution and By-laws it would be considered "ill-advised" for the reason that it would "open the door to an indefinite number of special interest groups and would defeat the pattern of consolidating all the Association's operating interests under a few standing Committees." Additionally, though the "desirable functions" of a group of medical care might very well transcend the functions of CAP, there was still the opinion of others who felt that APHA should not undertake "propaganda enterprises, but rather limit itself to a study of existing and desirable methods as used in public health." Atwater's candid opinion was that the Addendum had been tabled because "the considered judgment of a large majority of the CAP held the revision to be inexpedient . . . [and] among those holding this view were those of known liberal opinions in the field of medical care." If either the Executive Board or the Governing Council had been faced with the decision, noted Atwater, they also would have come to the same conclusion, and, that in regard to the Addendum, the Subcommittee would have been under no better situation had they been a separate standing committee. Atwater concluded that the Subcommittee was "structurally in its proper place," but understood and sympathized with "the sense of repression" the Subcommittee had experienced.[141]

Eliot also had been prompted to request information about the Subcommittee from another source. During the war, the federal government had sought and had been fortunate to gain the services of a number of energetic, dynamic and gifted young physicians. Working in various boards, bureaus, and departments of the government, many had been drawn together by their mutual interests and backgrounds, by Henry Sigerist's seminars at the Hopkins, by the Association of Internes and Medical Students, and by those who, convinced of the efficacy and need for a national health program, called themselves the "One Hundred Percenters for National Health Insurance." The 'Hundred Percenters was comprised of many of the early movers of the medical care movement who were then located in Washington, D.C., such as Joseph Mountin, Dean Clark, Edwin Daily, Frederick Mott, Palmer Dearing, and Edward Rogers. At meetings of this group, papers were read, legislation analyzed, and speakers invited to discuss current issues of medical care and health policy.

At one such meeting of the 'Hundred Percenters, in November 1947, Martha Eliot, then APHA president-elect, discussed the future of medical care. It was at this meeting that Milton Roemer, then secretary of the club, pressed the point that medical care deserved a more prominent place within APHA. The issues raised that night concerned the following factors: The enormous importance of the medical care field; the very cool reception to discussions of medical care topics within the Health Officers Section of APHA and the lack of any other existing forum to present such viewpoints; the frequent rejection of papers on medical care topics by *AJPH*; and the need for a national forum for discussion of medical care issues beyond the small boundaries of the 'Hundred Percenters, the Subcommittee on Medical Care, and the Physician's Forum. Counter-arguments were also heard, some of which already had been expressed when an attempt had been made to launch a new journal on social medicine to replace Michael Davis' journal *Medical Care*.

This proposed journal was to reach physicians, social workers, public health workers, and generally informed laymen interested in the social aspects of medical service. A prospectus had been prepared in June, 1946, and sent to 20 medical care specialists and subsequently to over 250 persons. Sent under the letterhead of the Physician's Forum, the prospectus contained information on objectives, need, and definition, and gave examples of the types of articles proposed for the journal including the historical development of group practice, chronic disease care under health insurance, medical care among Pennsylvania coal miners, the social basis of medical conservatism, the social costs of drug addiction, commercialization of the pharmacy, and the British National Health Act. That such articles had been referred to as "controversial" and the field of social medicine itself innovative is indicative of the manifest apprehension of those advocating social change in the mid-forties.[142] Opinions about the journal were varied but mostly were indicative of the fact that there might be something suspect about a journal devoted primarily to "social problems." E. Richard Weinerman, for example, cautioned against the overemphasis of the political and organizational aspects of health insurance on the one hand and on the other, cautioned against the journal becoming "ivory towerish." Vlado Getting wrote that if an "unbiased attitude would be maintained" the journal would be successful, while Dr. Antonio Ciocco of USPHS expressed the hope that the journal would not become "an organ of propaganda for a school of thought." Those two titans of public health, Haven Emerson and C.-E.A. Winslow, found so often in the forties on opposing sides of the debating rostrum, on this subject were in agreement. Emerson predictably was "forcefully opposed" to the proposal and charged

that it would probably be "a promotional and propaganda, perhaps politically partisan outlet for physicians and others who feel an urge to promote social theory rather than medical science." Winslow was opposed, but for the reason that the journal would be a "divisionary effort which, if successful, would narrow and limit the field of public health as we now conceive it."[143]

The arguments were rephased that night with respect to medical care and APHA. Some were opposed because APHA had become more sympathetic to their cause—in 1947, for example, over twenty articles on medical care topics had been published in the *AJPH*; others believed that the time was not yet ripe. Nevertheless, despite the opposition, Martha Eliot and others within the APHA hierarchy became allies of immeasurable strength. Eliot's belief in the validity of the argument that medical care was an integral component of public health, spurred on by the intense, argumentative, and demanding young government physicians,[144] doubtlessly prompted her query to Kline and the Subcommittee in late 1947.

Kline's belief that Eliot had planned to recommend Committee status for medical care proved to be mistaken; rather it was a new Section on Medical Care that was in the offing.

The Establishment of the Medical Care Section

In the late spring of 1948, Joseph Mountin appointed a Committee for the Creation of a Medical Care Section and shortly thereafter, under the letterhead of the CCMCS, Milton Terris, who had replaced Klein as Staff Director of the Subcommittee on Medical Care and who had been appointed by Mountin Secretary of the newly formed CCMCS, informed unaffiliated members as well as nonmembers of the Association that the creation of a Medical Care Section would be proposed to the APHA Governing Council later that year.[145] In a series of letters drafted by Terris, it was noted that there was no formal organization for individuals working in the various fields of medical care to meet together for the presentation and discussion of common problems. The Section envisioned was to provide "a medium for exchange of experience" with respect to program content, administration, and technical aspects of medical care. The Section also would be in a position to organize a series of joint sessions with other Sections; establish committees to study and report on specific subjects; and be represented in the Association Governing Council. The time for establishing a separate section, Terris had written, was propitious. Many physicians, dentists, nurses, and administrators of public and voluntary health agencies already had expressed an interest in organized health activities and even the Association had responded to this growing interest by organizing special sessions on medical care in 1944 and 1946. Moreover, the CAP Subcommittee on Medical Care had produced a number of special studies which had been received favorably; and joint policy statements with other professional organizations already had been published. It was also noted that papers on medical care topics had been published on a more regular basis in the *AJPH* during 1947.

The Subcommittee on Medical Care had been given responsibility for organizing two sessions on medical care and additionally had been permitted to participate in the planning for a number of joint sessions at the Annual Meeting scheduled for the second week of November. Terris requested the help of all interested parties in planning the special sessions and concluded with the hope that many would express their opinion on the creation of a Section on Medical Care by filling out an enclosed post card bearing the following items: "I am in favor of the creation of a Medical Care Section in the APHA, Yes or No; I am interested in membership in such a Section, Yes or No; Remarks; Name, Position, Address."

Seven hundred letters were sent that June to unaffiliated members and 2,500 to non-members of APHA. Over the summer, the response had been indeed encouraging. For example, a director of a school of social work and the Executive Secretary of the American Association of Medical Social Workers expressed "keen interest;" the director of the Kellogg Foundation noted that his Foundation would sponsor any Blue Cross executive wishing to join the proposed Section; hospital administrators, acknowledging their lack of "kinship" with the technical sections provided in APHA, seemed particularly interested in the new Section and believed, as did one respondent, that "without such a Section those of us in the hospital field have no place in the Association;" and others commented that "I can't help but believe that [the new Section] can have great influence on the Association" and that a Medical Care Section in APHA "could provide at this time the best meeting ground for those physicians and others interested in the development of medical care programs with a broad social base."[146]

Not only had many expressed their interest but over 500 individuals indicated their willingness to join the proposed Section.

While the special sessions on medical care scheduled for the annual APHA meeting were being planned by the Subcommittee on Medical Care, Terris was busily at work preparing a series of documents in support of the proposed Section on Medical Care. By October, the supporting evidence had been consolidated into two principal papers, the first a rather brief statement, mentioned in the preface of this paper, requesting the creation of the new section, and the second a more comprehensive document designed by Terris specifically for lobbying purposes, entitled "Synopsis of Arguments for a Medical Care Section."[147] This second document contained two major parts, "suggested arguments for a Section" and "possible objections." It was an impressive document and deservedly so. Terris had written that there had been in the forties, as a result of federal legislation and new interpretations of the role of the public health profession, an increasing concern and awareness of medical care issues, problems, and potential. Recent developments of programs for hospital survey, construction and licensure, the control of cancer, heart disease, and mental illness already had emphasized the interests and responsibilities of public health workers. Medical care teaching had been integrated into programs of schools and departments of public health at California, Harvard, Johns Hopkins, Michigan, North Carolina, and Yale, and the Subcommittee on Medical Care had studied the Maryland Medical Care Program and Regionalization in New England. Taken together, these recent developments and programs had made it imperative for those working in the fields of voluntary and public medical care plans, hospital service, group practice, chronic

diseases, and rehabilitation to meet together, exchange information, and discuss common problems.

APHA was the logical group to provide the "organizational medium" for the Section on Medical Care, Terris continued. After all, the Association had "great prestige" in the health field; it could easily provide the organizational framework necessary through regular sessions at the Annual Meetings and publication of papers on medical care in *AJPH*; it had a "unique scientific tradition" which would further the technical advancement of the medical care field; and, through its Executive Board and Governing Council, it could emphasize the close relationship of medical care with other aspects of public health. This relationship was cited specifically with health officers (general medical care programs administered by local health departments and the coordination of hospitals and health departments); public health educators (development of programs in hospitals and prepayment plans); epidemiologists (chronic disease); statisticians (utilization of morbidity data from hospitals and medical care programs); and those representing the fields of maternal and child health and school health (medical care for mothers and children).

The second section, "possible objections," was equally comprehensive. Here Terris supplied brief responses to such weighty questions as, "There are too many Sections in the Association" ("Medical care, however, is an important aspect of public health and deserves a definite and stable place in the Association . . . "); "The creation of a Medical Care Section would tend to isolate this subject from the health officers and other groups" ("The establishment of a Section on Medical Care would actually make it easier to integrate medical care with the interests of the health officers and other Sections through the mechanism of joint sessions . . . "); and "The Subcommittee on Medical Care is sufficient" (Yet Subcommittee membership was limited to fourteen. "Its primary functions relate to study and research by a staff supported by foundation grants which are reviewed annually. It cannot fulfill a Section's functions with respect to enrolling membership, developing a continuing program of independent and joint sessions for the Annual Meeting, and providing a forum for exchange of experience of the hundreds of individuals who are working in various fields of medical care.")

The 1948 annual convention in Boston promised to be a lively affair. Members of the Committee for the Creation of a Medical Care Section[148] involved in the promotion of their cause attended sessions, sought support from Council members and, in general, added a "political ingredient" to the deliberations. Since most of the addresses contained the expected preamble extolling the virtues of Lemuel Shattuck, a pleasant diversion was provided by those expressing their hope in a dynamic future rather than a review of the Association's well-recognized illustrious past.

Two special medical care sessions, "Improving the Quality of Medical Care" and "Medical Care Programs: Problems and Methods," and four joint sessions with the Public Health Nursing, Dental Health, Industrial Hygiene, and Engineering Sections had been scheduled by the Subcommittee and although popularly attended, most of the attention focused on the Governing Council meeting scheduled for late Wednesday afternoon in Mechanics Hall.

Martha Eliot, now president, convened the Council and the 86 members present proceeded with the routine business at hand.[149] The Council, for example, approved a number of resolutions, agreed to change the name of the Vital Statistics Section to Statistics Section, elected Fellows and Life Members, and considered a report from the Committee on Professional Education. At approximately six o'clock, Dr. Eliot recognized Dr. Hugh Leavell, who presented the petition for a new Section on Medical Care.[150] Leavell then moved that the plan be approved. After the second, Dr. C. Howe Eller, chairman of the Health Officers Section, was recognized and presented a resolution, which oddly was not made in the form of a motion and upon which no action was taken. Eller's resolution acknowledged the fact that health officers in their local jurisdictions had expressed interest in integrating into their community programs more expanded medical care programs and additionally noted that administrative health officers and the technical operators of medical care programs were in need of "considerable indoctrination in each others' responsibilities." A new Section, it was believed, would tend to divorce "such problems from the general administrative problems inherent in the provision of adequate health services." Therefore it was resolved, "that the Council of the Health Officers Section go on record that it feels that it is not advisable to establish an additional special Section at this time." The motion, then, expressed the surprising revelation that medical care programs should be integrated into the health department but, also, that the health officer should be responsible for their administration. It was rather a futile and transparent motion at best since the tradition-minded health officers had been extremely reluctant to accept such medical care programs and, moreover, had expressed this opinion whenever federal bills called for movement in that direction.

After the resolution had been presented, Haven Emerson spoke, followed by George Palmer, Vlado Getting, Ruth Freeman, and C.-E.A. Winslow. The two major discussants upon whom all attention focused during the debate were Emerson and Winslow, certainly the most venerable and august members of the Association. What they said in debate unfortunately was not recorded and there exists no extant copy of their presentation since they spoke extemporaneously as they had so often in the past. Their remarks to the Council, however, could not have varied very much from what they had thought and believed all their lives.

Both were over 70 years of age, but before the Council and its many guests that evening they appeared ageless. In 1940, Emerson had borrowed a quote from Isaiah Bowman who had said that "sentiment and emotion have their places in the evolution of society from lower to higher, but in themselves are fallacious guides."[151] The movements for health insurance, federal intervention in medical care and the expansion of public health, Emerson had believed, were all based on just such sentiment. He was fearful that the ambition of a few to achieve "collective salvation" had crowded science to one side. The social programs that had been urged upon the American people should be considered tentative and hypothetical until they had been subjected to the scientific method. We live in an age of "gimcracks and patent medicines;" only the public health profession, "the stabilizers of the soaring facts of

preventive medicine," can guard the "cause of nature," he had said. "We must not allow ourselves and our public functions to be diverted, by each new pressure group of financially plausible promoters, away from the basic job of essential public health administration." And when we have "builded a temple of health to shelter and include every human being . . . and have erected its four walls and floor and roof as symbols of the six principal structural elements of a modern health service then . . . should we devote our narrowly limited resources of dollars and doers of public health . . . to the decoration of the chambers, to the addition of new apartments or to new projects of secondary and doubtful importance."[152]

Winslow in 1948 might have believed that Emerson's "temple of health" had been constructed to wall society out rather than to protect it. How else could one explain Emerson's concept of medical care as "decorative and of secondary and doubtful importance?" Medical care belonged within public health; it had been kept outside for too long; too much had happened to ignore it any longer in good faith; APHA must respond to such changes as were apparent in society; public health was emergent, dynamic, and expanding, and not tradition-bound, insular, and narrow.

Winslow always had been proud of the fact that he had behind him ten generations of New England stock. He believed in the American traditions of freedom of thought and speech, open-mindedness and readiness to try experiments, initiative to work out the problems of society, and experimentation and progress.[153] Emerson doubtlessly had pointed out with reason and tolerance the pitfalls along the road of social progress, but such fears as Emerson had expressed, Winslow and others had believed exaggerated.[154] If there were better ways to mend society's ills than public housing, sickness insurance, and social security "let us find them," Winslow had said in 1947. "If not let us move forward . . . with hope and courage."[155]

Following the discussion, Dr. Eliot put the question and on a rising vote, the motion carried 55 to 16. Eliot then "declared the new Section on Medical Care as in existence immediately, with the officers and Section Council as proposed by Dr. Leavell duly elected."[156]

Conclusion

The controversy that had surrounded the establishment of the Medical Care Section, in a small way, was actually a reflection of deeper currents in American life.[157] The question in the late thirties and early forties, as it had been since the late decades of the past and the early decades of this century, was whether society should mature as a result of its own uninhibited forces and instincts or whether it should be modified and changed by federal legislation. And what of APHA and the health department? Should they expand their roles to envision not "basic" services but, as Joseph Mountin had believed, services which were "optimal" and which would raise the sights of public health far above routine and static activities? Such a transition in concept, he additionally had noted, would mean a "recognition of the realities of the day" and it would imply the "readiness, the willingness and the competence" to step in and take positive action wherever health problems were found to exist.[158]

The fundamental beliefs of Emerson and Winslow epitomized the struggle within APHA during this period. Should a profession, which many had believed wedded inextricably to the principle of scientific objectivity, permit itself to become involved with political considerations and paternalistic legislation which would dilute and confuse basic objectives; indeed, should the public health profession lay aside moral considerations and benevolence to support its authority as the dispassionate spokesman for the public interest; or, as Winslow and others had believed, should the health profession recognize that idealism, no less than dispassionate science, would lead society to the ultimate good?[159] Both Emerson and Winslow had been exposed to the ideas, attitudes and institutions prevalent at the turn of the century such as Darwinian natural selection, the Protestant Ethic, and the doctrine of classical economics. Both had witnessed the arguments that favored or opposed reform, protectionism, socialism, and interventionism. Both had grown up when the principle of thrift and individualism had been extolled as the greatest of American virtues.[160] Yet while Emerson had held tenaciously to a paradigm that increasingly was to become outmoded, Winslow had been capable of understanding and assessing the needs of an emergent society. Both, then, were compelling personalities, noble and aristocratic in appearance, ideal teachers who possessed qualities that endear them to posterity; but whereas Emerson was truly outstanding, he had missed greatness, while Winslow attained immortality.

The able men and women intent on legitimizing medical care, representing and reflecting the winds of change, had sought entrance to the "temple of health" at a time when its pillars were quivering. APHA endured their presence and as a result of its adaptability, it emerged as an envigorated, enlivened institution with new dedication, vision and purpose. But how ironic that the Medical Care Section, which so desperately had sought recognition now no longer has an identity that is recognizable. From modest beginnings to its present status as the largest group within the Association, this Centennial year is perhaps a propitious time to reevaluate goals and purpose. Borrowing a favorite phrase of Winslow's, should we not collectively wonder if our Section is at a "crossroads" and whether it is now time "to adopt new methods in order to meet new demands?" If there are self-doubts, let us not be afraid to confront them; if we are to advance, let us consolidate our strengths; and if we are to prevail, let us renew our faith in a worthy past, while being mindful that we should not be bound by it.

References

1. Constitution of the APHA. In: Public Health Reports and Papers . . . APHA, 1873. New York: Hurd and Houghton, 1875, p. xiii.
2. Winslow, C.-E.A. Public health and community well-being. Social Welfare, October 1927, 10, pp. 11-12. I am indebted to Professor Ira Hiscock for bringing this article to my attention.
3. First Report of the Committee on Municipal Health Department Practice of the APHA. AJPH, 12: pp. 7-15; 138-147, 1922.
4. Winslow, C.-E.A. Fifteen years of the C. A. P. AJPH, 25:1305-1306, 1935.
5. Committee on Administrative Practice. Appraisal Form for City Health Work. New York: American Public Health Association, 1926.
6. Annual Report of the Committee on Administrative Practice, 1926-1927 (Mimeo). Winslow MSS, I/CAP/4. The papers of C.-E.A. Winslow are in the Department of Public Health Collection, Sterling Memorial Library, Yale University. I am indebted to Miss Judith Schiff, Chief Reference Archivist, for her assistance in locating relevant documents in this collection.

7. Vaughan, Henry F. An Association with a future. AJPH, 15:1041-1045, 1925.
8. Winslow, C.-E.A. Public health at the crossroads. AJPH, 15:1075-1085, 1926.
9. See, for example, Commons, J. R. and Altmeyer, A. J. Special Report XVI. The health insurance movement in the United States. In: Report of the Health Insurance Commission of the State of Illinois. Springfield: 1919, pp. 625-647, and Report of the [California] Social Insurance Commission. Sacramento: 1917; 1919. See also Lubove, Roy. The Struggle for Social Security, 1900-1935. Cambridge, 1968 and Viseltear, A. J. Compulsory health insurance in California, 1915-1918. Journal of the History of Medicine and Allied Sciences, April 1969, 24:151-182.
10. Armstrong, D. B. Social uses of medicine. AJPH, 10:921-931, 1920.
11. Winslow, C.-E.A. Public health at the crossroads. op. cit., p. 1083.
12. Annual Report of the Committee on Administrative Practice, 1926-1927 (Mimeo). Winslow MSS, I/CAP/4.
13. Minutes of the Meeting of the CAP, September 23, 1927. Ibid.
14. Minutes of the Committee on Administrative Practice, May 23-24, 1928. Winslow MSS, I/CAP/4. See also: Relations Between Health Departments and Hospitals, a Sub-Committee of the Committee on Administrative Practice. Presented to the Health Officers Section of the American Public Health Association . . . October 19, 1927. AJPH, 18:290-299, 1928.
15. Minutes of Meeting of the Committee on Administrative Practice, December 6, 1928. Winslow MSS, I/CAP/4.
16. Statement by the Subcommittee on Organized Care of the Sick. Included in: Association News, Community Health and Hospital Survey. AJPH, 18:348, 1928. See also: Health Officers' Section, News Letter, January 1928 and C.-E.A. Winslow to Michael Davis, September 22, 1933. Winslow MSS, II/18/19.
17. Minutes of the Meeting of the Committee on Administrative Practice, December 13-14, 1935. Winslow MSS, I/CAP/4. See also Davis to Members of the Subcommittee on Organized Care of the Sick, November 20, 1935. Ibid.
18. Lemuel Shattuck had written that: "The condition of perfect public health requires such laws and regulations, as will secure to man associated in society, the same sanitary enjoyments that he would have as an isolated individual; and as will protect him from injury from any influences connected with his locality, his dwelling house, his occupation, or those of his associates and neighbors, or from any other social causes." Cited in: Selected Papers of Joseph W. Mountin, The health department's dilemma; definitions and functions (1952), p. 60.
19. Sigerist, Henry E. The medical student and the social problems confronting medicine today. Bulletin of the Institute of the History of Medicine, 4:411-422, 1936.
20. Ibid., p. 412.
21. Ibid., p. 415. For example, "Medicine the way we practice it today is a service that is being sold by the physician and purchased by the patient. Medicine, therefore, definitely has an economic aspect. It has to fit into an economic system. How can we discuss any of these features if we do not know the elements of economics, if we do not know the mechanism of production, what wages are and what determines wealth or poverty in a society. Without economics there is no understanding . . . [Further] you can not afford to be disinterested in sociology. The physician is serving society. He has to fit himself into a given structure of society. He has to see patients who come from all strata of society and has to treat diseases that are quite often due to an environmental influence." Ibid., p. 416.
22. Ibid., p. 422.
23. Address by John Peters, Journal of the Association of Medical Students, May 1937, 3, p. 4.
24. Peters, John. Improvement of medical care. Ibid., p. 12.
25. Ibid., p. 11.
26. See, for example: Sigerist, Henry E. A History of Medicine. Volume I. New York, Oxford, 1955, pp. 3-37 and his Medicine and Human Welfare. New Haven: Yale University Press, 1941.
27. Sigerist, Henry. The medical student . . . , op. cit., pp. 418-421. These later, contemporary medical care topics included analyses of the Committee on the Costs of Medical Care, the development of social insurance in Europe and the United States, the Social Security Act, and voluntary and compulsory health insurance.
28. Sigerist, Henry. Socialized Medicine in the Soviet Union. New York: W. W. Norton and Co., 1937.
29. See, for example, Sigerist, H. E. Socialized medicine. Yale Review, 27:463-481, 1938; The realities of socialized medicine. Atlantic Monthly, 163:794-804, 1939; and articles on eighteen medical service plans published in the New York newspaper PM between the dates July 15, 1940 and November 15, 1940.
30. Sigerist, Henry E. Does America Need Compulsory Health Insurance? Broadcast from Town Hall, New York City, January 18, 1940. On the same program were C.-E.A. Winslow of Yale and Dr. Terry Townsend, President of the New York State Medical Society. Sigerist's speech was reprinted in The Interne, 6:208-209, 221, 1940. Townsend's appeared in the June and Winslow's in the August 1940 numbers.
31. Obituary written by John Fulton. Science, June 8, 1956, 123, p. 1023.
32. Peters, John. Story of the principles and proposals for the improvement of medical care. New Eng. J. Med., November 25, 217:887-890, 1937.
33. Peters, John. Improvement . . . . op. cit., p. 30.
34. See, for example, Peters: Medicine and the public. New Eng. J. Med. March 23, 220:504-510, 1939; The social responsibilities of medicine. Ann. Int. Med., October 4, 1938, 12:536-543; and: The social implications of medical science. Yale Journal of Biology and Medicine, January 1942, 14:279-290. The Committee of Physicians for the Improvement of Medical Care proved to be only mildly insurgent. They had never endorsed compulsory health insurance, for example; nor had they ever repudiated AMA policy or wished to create a rival organization to speak for the American medical practitioner. Rather, the Committee's function was to generate publicity and encourage the AMA to cooperate with government in reforming certain medical care practice. As such it provided a very useful purpose in stirring up health discussion throughout the medical world. See: Hirshfield, D. S. The Lost Reform; the Campaign for Compulsory Health Insurance in the United States from 1932 to 1943. Cambridge: Harvard University Press, 1970, pp. 128-129.
35. Davis to Members of the Committee on Research in Medical Economics, September 20, 1937. SSA/OC, 47/62A-82/4. The records of the Office of the Commissioner, Social Security Administration, are stored at the National Records Center in Suitland, Maryland. I am indebted to Mr. Mearn Thompson, Archives Technician, Reference Branch, National Records Center, for his assistance in locating relevant manuscripts in this extensive collection.
36. Ibid.
37. Comprised of Josephine Roche, Chairman, Arthur J. Altmeyer (Social Security Board). Oscar L. Chapman (Interior), Charles V. McLaughlin (Labor), and Milburn L. Wilson (Agriculture). Added in 1938 were Thomas Parran (Public Health Service) and Aubrey Williams (Works Progress Administration).
38. Winslow, C.-E.A. Discussion of Report of Technical Committee on Medical Care. Proceedings of the National Health Conference, July 18, 19, 20, 1938 . . . Washington: G.P.O., 1938, p. 150.
39. Comprised of Martha Eliot (Children's Bureau), chairman, I. S. Falk (Social Security Board), Joseph W. Mountin (Public Health Service), George St. John Perrott (Public Health Service) and Clifford E. Waller (Public Health Service).
40. Roche, Josephine. Our national health. The Interne, July 1938, 4:185-188.
41. See: A National Health Program: Report of the Technical Committee on Medical Care. In: Proceedings . . . , op. cit., pp. 29-64.
42. See: Toward Better National Health. Washington: G.P.O., 1939, p. 27, and Proceedings . . . , op. cit., p. 64.
43. Fishbein, Morris. Discussion . . . , in: Proceedings . . . , op. cit., pp. 115-118.
44. Hamilton, Alice. Ibid., p. 132.
45. Winslow, C.-E.A. Ibid., p. 151.
46. The need for a national health program; report of the Technical Committee on Medical Care. AJPH, 28:506-508, 1938.
47. Ibid., December 1938, pp. 1441-1442.
48. Ibid., p. 1442.
49. The Committee was comprised of Abel Wolman, Chairman, J. N. Baker, Louis Dublin, A. T. McCormack, H. S. Mustard, J. L. Rice, F. J. Underwood, and E. S. Godfrey and Reginald Atwater, ex officio.
50. Report from the Committee of the American Public Health Association Appointed to Confer With the Interdepartmental Committee to Coordinate Health and Welfare Activities and With Other Agencies, as Approved by the Executive Board October 17, 1938. November 19, 1938. Winslow MSS, I/12/12.
51. Ibid., pp. 2-3. The sentiments expressed in this report, however, were not universally approved. See infra: Haven Emerson, Joseph Mountin, and Social Progress.
52. Hall, Helen and Kellogg, Paul. The unserved millions. Survey Graphic, September 1938, 27:474.
53. Mountin, Joseph. Signs of change in the medical scene. The Interne, 5:237, 1939.
54. The complete bill may be found in U.S. Congress, Hearings Before a Subcommittee of the Committee on Education and Labor, United States Senate, Seventy-Sixth Congress, First Session, on S. 1620 . . . Part 1, April 27, and May 4, 5, 11, and 12, 1939. Washington: G.P.O., 1939, pp. 1-16.
55. Mountin, Joseph. Signs . . . op. cit., p. 250. The Interne Council in 1939, incidentally, chose not to express its editorial opinion on the Wagner Bill until its membership had a chance to respond to a referendum. This policy, they believed, was "in line" with the traditional democratic policy of the Interne Council. "We do not believe the leadership of any democratic group has the right to speak for the general membership on so important and controversial a question unless it knows definitely the feeling of the membership." The Interne, 5:111, 1939.
56. Obituary in AJPH, 47:1009-1011, 1957.
57. Emerson, Haven. Public health awaits social courage. AJPH, 24:1006, 1934.
58. Ibid., p. 1009-1022.
59. Hearings . . . , op. cit., p. 339.
60. Ibid., p. 340.
61. Ibid., p. 342.
62. Ibid., p. 349.
63. Wolman, Abel. Hearings . . . , op. cit., pp. 130-137.
64. Ibid., pp. 137-139.
65. Ibid., p. 139. The main exception was that the Wagner Bill had failed to make a single Federal agency responsible for all features of the Bill, choosing instead to spread responsibility among the Children's Bureau, the Public Health Service and the Social Security Board.
66. Ibid., p. 139. See also: Wolman, A. A Statement of the position of the APHA with reference to . . . S.1620 . . . AJPH, 29:686-688, 1939.
67. Emerson, Haven. The physician's part in organized medical care. AJPH, 30:9, 1940.
68. Ibid., p. 14.
69. Ibid., p. 16.
70. Mountin, Joseph. Administration of public medical service by Health Departments. AJPH, 30:138-144, 1940.

71. Ibid., p. 140.
72. Ibid., p. 144.
73. Emerson to Winslow, April 24, 1939 and Winslow to Emerson, May 1, 1939. Winslow MSS, II/18/22 and Davis to Emerson, May 23, 1939 and Emerson to Davis, May 16, 1939. SSA/OC, 47/62A-82/4. See: Emerson, Politics and Public Health. America's Future, Mid-Spring, 1939, pp. 3, 25. In the same issue there were articles by Ray Tucker and H. L. Mencken under the title, "How our Doctors Have Been Pushed Around" and an editorial denouncing the Wagner Bill written by editor-publisher Frank Gannett.
74. Emerson to Davis, ibid.
75. Davis to Atwater, February 26, 1940. USPHS/GF, IX, RG 90/154. Public Health Service documents are stored at the National Archives, Washington, D.C. I am indebted to Mr. Carmen Delle Donne and Mr. Joseph B. Howerton, Archivists, Industrial and Social Branch, National Archives, for their help in locating pertinent MSS.
76. See, for example, Emerson, Kendell. Responsibility of organized medicine in medical care. AJPH, 30:1171-1176, 1940, and Mountin's Administration of public medical services by health organizations, ibid., 30:138-144, 1940. These papers should be compared to Haven Emerson's "The physician's part in organized medical care." Ibid., 30:9-16, 1940.
77. Mountin, J. W. Subcommittee on Organized Care of the Sick; Purpose and Program, April 6, 1940. USPHS/GF, IX, RG 90/154.
78. Minutes of a Meeting of the Subcommittee on Organized Care of the Sick of the CAP, March 24, 1941. Ibid.
79. Ibid.
80. Mountin to Atwater, November 26, 1943. Subcommittee on Medical Care MSS. The manuscripts of the Subcommittee on Medical Care (SbMC) recently have been deposited in the Sterling Medical Library, Yale University. I am indebted to Beverlee Myers and Jerry Solon, of the Health Services and Mental Health Administration, and both past Secretaries of the Section on Medical Care, APHA, for wisely deciding to preserve this collection.
81. Atwater to Mountin, November 4, 1943. SbMC MSS.
82. An official declaration of attitude of the APHA on desirable minimum functions and suitable organization of health activities. AJPH, 30:1099-1101, 1940.
83. Atwater to Henry F. Vaughan, December 30, 1943. SbMC MSS.
84. Minutes of an Informal Group Called to Consider the Medical Care Aspects of the Work of the Committee on Administrative Practice . . . January 8, 1944. SbMC MSS.
85. Falk to Atwater, January 17, 1944. SbMC MSS.
86. Mountin to Falk, January 29, 1944. SbMC MSS.
87. Minutes of an Informal Group . . . January 8, 1944. Op. cit.
88. Minutes of the Meeting of the Subcommittee on Medical Care of the CAP, February 11, 1944. SbMC MSS.
89. Atwater to Wolman, February 15, 1944. SbMC MSS.
90. Ibid.
91. Editorial. The Second Wartime Public Health Conference. AJPH, 34:1185, 1944.
92. Minutes of the 2nd Meeting of the Subcommittee on Medical Care of the CAP, April 13, 1944. SbMC MSS.
93. Minutes . . . February 11, 1944. Op. cit.
94. I. S. Falk was the sole author of the first memorandum, "Some Notes on a National Health Service and a General Medical-Care Program (Prepared for the Subcommittee on Medical Care), April 4, 1944. Winslow MSS, II/19/23.
95. Minutes of the 2nd Meeting . . . April 13-14, 1944; Minutes of the 3rd Meeting . . . June 1-2, 1944. SbMC MSS.
96. Published in the September, 1944 AJPH.
97. Hospital care, the services of physicians (general practitioners and specialists), supplementary laboratory and diagnostic services, nursing care, essential dental services, and prescribed medicines and appliances.
98. Such services were to include maternal and child hygiene, school health services, control of communicable diseases, special provisions for tuberculosis, venereal diseases, and other preventable diseases, laboratory diagnosis, nutrition, health education, vital records, and other accepted functions of public health agencies, which were then, the report states, provided for only a part of the population.
99. Leavell was named liaison to the Subcommittee on Medical Care by the Executive Board. Minutes of a Meeting of the Executive Board, January 28, 1944. Winslow MSS, I/APHA/2-3.
100. Leavell, Hugh. Landmarks of 1944; Medical Care in a National Health Program. AJPH, 35:16, 1945. Mountin earlier had expressed similar sentiments. In a letter to Marian Randall, Executive Director of the Visiting Nursing Service of New York and a co-member of the Subcommittee on Medical Care, he noted that the "sole purpose [of the report] was to try to induce the APHA to declare its intention in the provision of medical care and to suggest to health departments that they should look forward to having some place in the scheme of administration." Mountin to Marian G. Randall, September 15, 1944. USPHS/GF, IX, RG 90/153.
101. Halverson to Emerson, June 29, 1944. SbMC MSS.
102. Emerson to Halverson, August 2, 1944. SbMC MSS.
103. Ibid.
104. Halverson to Emerson, August 5, 1944. SbMC MSS.
105. Halverson to Atwater, August 14, 1944. SbMC MSS.
106. Atwater to Halverson, August 19, 1944. SbMC MSS.
107. Ibid.
108. Reginald Atwater to Members of the CAP, August 22, 1944. Winslow MSS, II/APHA/2-3.
109. The additional paragraph read as follows: "The American Public Health Association through its national organization and its constituent societies stands ready to collaborate with the various professional bodies and civic organizations who may be concerned with either the provision or receipt of medical service with a view to implementing the foregoing general principles." Additionally, the phrase "regardless of the financial means of the individual, the family, or the community" in paragraph 1 under "Objectives" was deleted and the statement of "Needs" was to precede the statement of "Objectives." Document, "Changes in Report of Subcommittee on Medical Care," no date. Winslow MSS, I/APHA/2-3. See also, "Medical Care in a National Program; An Official Statement of the American Public Health Association. Adopted October 4, 1944," AJPH, 34:1252-1556, 1944.
110. Minutes of the Meeting of the CAP of the APHA Held on Sunday, October 1, 1944 at 10 A.M. in the Hotel New Yorker, N.Y. Winslow MSS, I/APHA/2-3.
111. Minutes of the Second Meeting of the Governing Council . . . October 4, 1944 . . . . Winslow MSS, II/APHA/2-3. See also "Association News," AJPH, November 34:1202-1203, 1944.
112. Smillie, W. G. An appraisal of a national program for medical care (after ample opportunity to study the proposals). AJPH, 35:587-592, 1945.
113. Ibid., p. 587.
114. Ibid., p. 588.
115. Ibid., p. 588.
116. Ibid, p. 589. See: Mountin, J. W. Comment and administration of a medical care program; a brief of the report on medical care in a national health program. AJPH, 34:1217-1222, 1944. Mountin and others actually had meant "administration at each level of government" not at all levels.
117. Ibid., p. 590.
118. Ibid., p. 591.
119. Ibid.
120. Editorial. Constructive thinking about medical care. AJPH, 35:159-162, 1945.
121. Report of the Health Program Conference, Principles of a Nation-wide Health Program, New York, Committee on Research in Medical Economics, 1944.
122. For example, here were Ernst Boas, J. Douglas Brown, Allan Butler, Hugh Cabot, Dean Clark, Michael Davis, I. S. Falk, Channing Frothingham, Franz Goldmann, Alan Gregg, Frederick Mott, George St.J. Perrott, John Peters, Kingsley Roberts, C.-E.A. Winslow, Edwin Witte, and others.
123. These were: Comprehensive coverage and service; spreading of costs; distribution of facilities according to community health requirements; encouragement of group medical practice with hospitals as professional service centers; determining policy through participation of those who receive and of those who furnish service; responsibility of the professions for strictly medical activities; freedom for physicians and patients; adequate payment of physicians and hospitals by methods which encourage quality and promote economy of service; a national system; and local administration of services under national standards. Principles . . . op. cit., p. 3.
124. Physician's Forum. Program of Conference on Problems of Medical Care, December 8 & 9, 1944, Washington D.C. N.d. [1944]. See especially pp. 1-46.
125. This fact should not be surprising since many of the same principal players were participants in all three deliberations.
126. Constructive thinking . . . , op. cit., p. 162.
127. Hugh Smith to Reginald Atwater, December 4, 1945. SbMC MSS. John Grant of the Rockefeller had been recognized by many as the Subcommittee's benefactor. See: Seipp, Conrad. (Ed.), Health Care for the Community; Selected Papers of Dr. John B. Grant. Baltimore: Johns Hopkins Press, 1963.
128. The Administration of Medical Care Programs. A Memorandum of the Subcommittee on Medical Care of the CAP, APHA, December 1, 1945. SbMC MSS.
129. Ibid. See also Atwater to Mountin, December 4, 1945. SbMC MSS.
130. The Administration . . . , op. cit.
131. Report of Activities; Subcommittee on Medical Care, September 1946. SbMC MSS.
132. Addendum to the Official Statement of the APHA of October 1944, on Medical Care in a National Health Program. September, 1946. Winslow MSS, I/APHA/2-3.
133. Vlado Getting to Wilton Halverson, November 4, 1946. SbMC MSS.
134. Ibid.
135. Halverson to Getting, November 6, 1946. SbMC MSS. The APHA, however, already had presented its positions to Congressional Committees. Mention has been made to the Wagner Bill and in 1945 Reginald Atwater had presented a statement of the Hill-Burton bill (S. 191). See, editorial: The Hill-Burton bill. AJPH, 35:380, 1945. Mountin, in his capacity as Medical Director of the USPHS, also had presented testimony in behalf of the Wagner-Murray-Dingell bill (S. 1606). See: Mountin, J. W. Statement. U. S. Congress, Hearings before the Committee on Education and Labor, U. S. Senate, Seventy-Ninth Congress, Second Session on S. 1606 . . . Part 1. April . . . 1946. Washington: G.P.O., 1946, pp. 134-168 and editorial, The Wagner Bill, AJPH, 35:824-825, 1945.
136. Special article. Planning for the chronically ill; joint statement of recommendations by the AHA, APWA, APHA, and AMA. JAMA, 135:343-347, 1947. Also in AJPH, 37:1256-1266, 1947. For further explanation, see editorial, "The problems of chronic illness," ibid., pp. 1339-1340.
137. Coordination of hospitals and health departments; joint statement of recommendations by the AHA and APHA. AJPH, 38:700-708, 1948.
138. See: Roberts, Dean W. The health department and medical care; the Maryland Medical Care Program. AJPH, 37:259-263, 1947.
139. Kline to Atwater, December 24, 1947. SbMC MSS.
140. Falk to Atwater, October 22, 1946. SbMC MSS.
141. Atwater to Falk, October 25, 1946. SbMC MSS.

142. See, for example, editorial: Who is Un-American now? AJPH, 37:1592-1595, 1947.
143. Winslow's reaction to the proposed journal of social medicine warrants further explanation. In 1940, when Michael Davis had developed the idea for his own quarterly journal, *Medical Care*, Winslow expressed his "thrill" that such a journal had been planned. Winslow, together with Ernst Boas, Samuel Bradbury, Claude Munger, John Peters, Herbert Phillips, Kingsley Roberts, and George Soule served on the new journal's editorial board. When Davis began "to tire" of the quarterly in 1944, it was to Winslow that he had turned for advice. Winslow attempted to revive Davis' spirits, writing that "No movement can thrive and prosper without a dignified organ for the publication of research and the enunciation of considered opinion. [If *Medical Care* were permitted to go under] it would be a "major tragedy, a very serious blow." When Davis had concluded definitely that he would discontinue the journal Winslow again counseled reason. "*Medical Care*," he wrote, "is at the very heart of our battle for rational medicine in this country." If abandoned it would "be justly hailed in [AMA headquarters] as a major victory." Why then Winslow's lack of enthusiasm for a proposed journal of social medicine that seemed to wish to begin where *Medical Care* had left off? The answer perhaps lies in the fact that by 1946/47, Winslow and other progressives in the APHA "corridors of power" had won the battle to open the *AJPH* to medical care papers. The proposed journal would, as Winslow expressed, be "divisionary" just when the quest for respectability was within its grasp. The Davis-Winslow, Winslow-Davis correspondence may be found in the Winslow MSS, II/18/19. See especially those letters dated January 22, 26, 1940; February 8, 14, 1944; March 8, 1944; and July 21, 26, 1944. I am indebted to Milton Roemer for providing me with a copy of the memorandum "Proposed Journal of Social Medicine," June 5, 1946.
144. Such as Solomon Axelrod, Harry Becker, Leslie Falk, Henry Makover, Milton Roemer, and others.
145. Milton Terris to Dear Fellow Members, June 10, 1948. Terris MSS. I am grateful to Milton Terris for providing me with this document and other documents pertaining to the establishment of the Medical Care Section.
146. Document: Comments Received on the Proposed Medical Care Section of the American Public Health Association. No date, [1944], Terris MSS.
147. Document: Request for Creation of a Medical Care Section of the American Public Health Association. No date [October 1948] and Synopsis of Arguments for Medical Care Section of American Public Health Association. No date [October 1948], both Terris MSS.
148. The members of the Committee were: Elin Anderson, George Baehr, John Bourke, Dean Clark, Edwin Daily, Graham Davis, V. L. Ellicott, I. S. Falk, John Ferrell, Vlado Getting, Fred Jackson, Hugh Leavell, Morton Levin, Herbert Lombard, Basil MacLean, Thomas McKneely, Frederick Mott, Joseph Mountin, Martha O'Malley, Ellen Potter, Marian Randall, Lowell Reed, Dean Roberts, Edward Rogers, David Rutstein, Emilie Sargent, Nathan Sinai, Lucille Smith, R. M. Walls, John Williams, Jr., John Wittmer, and Milton Terris, Secretary.
149. Minutes of the Second Meeting of the Governing Council, APHA . . . November 10, 1948. SbMC MSS.
150. For a synopsis of Leavell's statement see the Preface to this paper.
151. Emerson, Haven. The physician's part in organized medical care. AJPH, 30:9, 1940.
152. Emerson, Haven. The unfinished job of essential public health service. AJPH, 38:166, 1948.
153. Winslow, C.-E.A. Poverty and disease. AJPH, 38:184, 1948.
154. Winslow, C.-E.A. Introduction. Selected Papers of Haven Emerson. Battle Creek: W. K. Kellogg Foundation, 1949, p. xviii.
155. Winslow, C.-E.A. Poverty . . . , op. cit., p. 184.
156. Ibid. The new officers were: Edward Rogers, chairman, Edwin Crosby, vice chairman, Milton Terris, secretary and Dean Clark, Edwin Daily, Herbert Lombard, Ellen Potter, and Martha Randall, members of the Section Council.
157. Roemer, Milton. Chairman's address: The Section Ten Years After, reprinted in Medical Care Section News Letter, number 26. December 1957. Terris MSS.
158. The health department's dilemma (1952). In: Selected Papers of Joseph W. Mountin, M.D. Joseph W. Mountin Memorial Committee, 1956, p. 64.
159. These ideas have been expressed with great clarity by Barbara Gutmann Rosenkrantz. See: Public Health and the State; Changing Views in Massachusetts, 1842-1936. Cambridge: Harvard University Press, 1972, pp. 129, 178.
160. See: Hofstadter, Richard. Social Darwinism in American Thought. Revised Edition. Boston: The Beacon Press, 1958 (1944), chapters three and four. See also Haven Emerson's Society and medicine. In Selected Papers of Haven Emerson. Battle Creek: W. K. Kellogg Foundation, 1949, pp. 343-352.

ACKNOWLEDGMENT

In certain references to this paper I have made mention of the archivists and librarians who assisted me in locating pertinent documents and manuscripts in the extensive holdings of the National Archives, the National Records Center and Yale's Sterling Memorial Library. I could not have completed this paper, however, without the information and/or criticism provided me by: Solomon Axelrod, Pearl Bierman, Edward Cohart, Leslie Falk, I. S. Falk, Ruth Freeman, Vlado Getting, Ira Hiscock, Milton Roemer, George Rosen, Cecil Sheps, George Silver, Jerry Solon, and Milton Terris. Their insights confirm the fact that our recent past should be preserved by establishing oral history programs and a public health manuscript's library. It is necessary to add that any errors in interpretation, fact or judgment found in this paper are mine alone.

Dr. Viseltear, Archivist of the Medical Care Section, is Assistant Professor of Public Health (Medical Care), Department of Epidemiology and Public Health and Research Associate in the History of Medicine, Department of the History of Science and Medicine, Yale University School of Medicine, New Haven, Connecticut.