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JUSTICE AND THE FUTURE OF MEDICINE [1]

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Let me confess that I stand somewhat in awe of my subject. Justice, medicine, the future, are all mysteries about which man can know little. My profession is the law, which aspires to, even though it does not always attain, justice; about it I know enough to be very humble in my knowledge. Your profession is medicine; about it you are far more conscious than I of the vistas which have not been reached and the depths which have not been probed. The future hangs upon far too many things which are alien to your shop and to mine for either of us to boast that he can chart its course. If I am a layman in respect to medicine, you are laymen in regard to law. But the fact that we differ in calling and in experience is an asset. It enables us to speak our separate minds, to compare our viewpoints, to sharpen our differences, to move toward a common understanding.

The law is no mean challenge to the human understanding. Yet my admiration goes out to you doctors for the greater mystery which you have set yourselves to unravel. For a casual Nature has spent countless aeons in putting together that bewildering organism we call Man, and a process of discovery has used up milenniums in finding out enough about how the trick was done to help Man over ills and aches toward health. It has taken courage, intelligence, a myriad of guinea pigs, and the sacrifice of a thousand ancient truths to come as far as you have on a trail which still leads into the unknown.

For the Man, of which medicine is mindful, is a curious and wonderful thing. A long course of cosmic, geologic, and biologic events has made of him the permutation of things which anatomically he is. Nature, a slow and uncertain workman, took a fraction of eternity in which to make trys, beat retreats, blunder along her creative way. She achieved in Man a result which, if nothing to brag about, is at least passable. The chances against his being here at all are as legion to one; the chance of his being exactly what he is—well, write your own odds.

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But the biologic process alone did not create man. Every human being has a distinct culture stamped all over him. At work and at play he is beaten upon by a continuous stream of stimuli from the human life pulsing about him. In taking care of himself, finding a way of life, begetting posterity, going on a tear, his pursuit of happiness is pent in by the prevailing culture. Man cannot exist apart from the ways and the beliefs of the folk. We are all of us products alike of the earth and of culture. Adjustment to nature and to society, always in process yet never completed, is the condition of our life.

Thus the patient—a curious and stubborn bundle of organs and ailments and resistances—presents a series of enigmas which challenge the skills of the doctor. Man, upon whom all medicine converges, is ancient in contrast to the youthful art which serves him. He was established in his anatomical estate and fitted out with his physiological heritage long before the "physician" was so much as a word. He bears in structure and function, in organ and senses, the impress of all that the life back of him has met in the ages it has passed through and, to complicate the problem, he is infinitely variable. The mixture of genes, chromosomes, and unit characters into fresh combinations in every individual makes each of us a new experiment. In a word, the doctor's challenge is not a standardized man. My hat is off to the man of medicine for the sheer audacity of the task he has undertaken.

From the medicine man of old to the modern clinic is a long way. Again and again mystery after mystery has been probed; again and again the utterly impossible has won acceptance against ancient truth; again and again the reach of medicine has been enlarged. The doctor's craft, with triumph after triumph to its credit, is still on its way. Yet it is set within a larger problem of human well-being which up to now has hardly been explored. It will not be solved until we learn to make culture in all its color and drama an instrument of health.

Institutions of some sort must be set up to serve each of the great needs of life. A people must be fed, given laws, protected against the weather, held to a moral code, provided with escapes from the dullness of everyday existence, fitted out with the comforts and frivolities which make life worth living. As we jog down the centuries and over the globe the ways in which these great tasks are performed present a most kaleidoscopic picture. If the job be to appease the gods, educate the young, ward off plagues, each people has its own way of doing it. Nowhere is there a final answer; there is always bother and striving that it may be better done.

Now the health of the people is among the mightiest of these great tasks. Yet the problem of the adequacy of medical care is unusually baffling. For it is only the exceptional person who has experienced all

the arts—technical, economic, cultural—which converge in it. A beginning of understanding lies in a recognition of a distinction between the technology of medicine and its organization. By technology I mean all of those arts of diagnosis, therapeutics, surgery, radiology, dentistry, and the like, which constitute the profession of medicine. By organization I mean all of the arrangements, social and economic, by which medical service is made available. It is idle to dispute as to which is the more important; for there must be a medicine to practice, and there must be arrangements for bringing physician and patient together. It is no veiled mystery as to which is the more backward. In the advance of the art of medicine, you have done a brilliant job. In the face of this advance it is all the more tragic that progress in the organization of medicine has lagged and, because of this lag, the nation has not had the full benefit of your superlative performance.

For backwardness in organization I am not disposed to pass out blame. But we should be quite frank in looking into reasons. You must be able to state your problem before you can solve it; and I wonder if a primary cause of the backwardness is not a failure to put the question clearly. Is not confusion found in attitude, in approach, at the very beginning of inquiry? To be specific, I profess no knowledge of the practice of medicine, and should I attempt to "lay down the law" as to how to treat an ailment you could—and quite properly—laugh me down. Yet, as a group, physicians have been little exposed to the discipline of the social sciences, and social organization is as intricate and as full of mysteries as the art of medicine itself. So when I hear a physician speaking about the organization of medicine in a tone of doctrinaire finality, I cannot fail to remark the contrast with the courageous and humble search for truth displayed in his own work. And when I hear the question put as a choice between private practice and socialized medicine, I cannot escape noting a confusion and dogmatism strikingly different from the scientific approach. As for the "either or" of private practice and socialized medicine, there is no such question. There are a myriad of schemes under which the doctor and the patient may be brought together—not a choice between just two.

Here, then, is the main reason for the great lag of organization behind art. Organization must be shaped in the full knowledge of the economic and social arts, yet it also must be shaped to the art of medicine and the distinctive service it renders. Advance, then, depends upon a range of understanding which neither you and your kind, nor I and my kind, alone possess. It demands a cooperation of professions which is not yet an accomplished fact. As we now take counsel together we are not going to clear up the problem. But this is the kind of thing, multiplied a myriad of times over, out of which

will some day emerge the answer to the question of justice and the future of medicine.

Down through the centuries the common law has recognized the maintenance of the common health as one of the great tasks of society. In Europe, and in America, there never was such a thing, strictly speaking, as the private practice of medicine. From the earliest days the common law has made this clear. It is true that from days of old the doctor held no public office, but his service was, as the judges put it, "clothed with a public interest." At a time when any man, butcher, mercer, wheelwright, baker, fishmonger, or candlestick maker, was free to enter the trade of his choice, a license was required of the doctor. To secure his right to practice the candidate had to prove his knowledge, his integrity, his skills. The physician was not free to select or to reject patients at will. As one who followed a common calling he held himself ready to serve all in need to the limit of his capacity. Nor was inability to pay a valid excuse for the refusal of his service. The law recognized him as a kind of unofficial servant of the community and exempted him from the ordinary rules of the market. It wisely refused to crowd the relation of doctor and patient into the elementary forms of trade. The doctor rendered a service, the patient, if he was able, paid a fee, but the courts refused to regard the matter as a business deal.

On the contrary the law judged the relation by reference to the norm of common health. It was recognized that the patient, unversed in the mystery, was unable to judge the quality of service. Hence the doctor, in taking a case, assumed a trust unknown in respect to trade at large. The courts steadfastly refused to bring the rights and duties of the parties involved under the ordinary law of contract. And even in days when any old bargain was held valid, I have yet to discover a case in which a bungling physician was allowed to get off with a plea of caveat emptor.

The law went to lengths unknown elsewhere to make certain that the common health was served. In respect to the wares of trade the law of single price usually holds; a commodity is available to all who wish to purchase on exactly the same terms. To insure adequacy of service, a special rule of law was decreed for the physician; he was permitted to charge different fees to patients differently situated. The sliding scale, as much later it came to be called, served a definite social end. It elevated medicine above commerce, broke the pecuniary connection between the doctor's service and his reward, and gave legal recognition to the principle that persons were to be served according to their needs, that charges were to be assessed in terms of ability to pay.

Not so long ago, in my official work, the public character of the doctor's calling was vividly brought home. It is a matter of public

record, so I might as well confess. I was one of "the small group of willful men" who instituted the antitrust suit of the United States against the American Medical Association. The occasion, you will recall, was a boycott by the Medical Society of the District of Columbia of certain physicians employed under a group health plan. The Society had expelled one physician, forced a second to break his contract, and denied hospital facilities to their patients. Had the issue been between rival schools of medical practice, I, as a layman, would not have been entitled to an opinion. But both group health and the medical society stood for orthodoxy; there was no difference there. Had the question been a choice between two out of many ways of organizing medical service, I could in time have arrived at my own answer. But I should have wanted to get all the facts, examine experience critically, and think hard and long before deciding. But the issue was far simpler; it was merely a question of a fair field and no favors between two rival—and it seems to me immature—plans for bringing doctors and patients together. To us the American Medical Association seemed to be attempting to keep group health from having an opportunity to prove or to disprove its case. And we were convinced—the courts have now agreed with us—that the tactics were clearly illegal.

As the case went forward, this notion of medicine as the instrument of the common health was the Government's mainstay. Again and again we had occasion to recite the public character of the physician's office. There was a time when an association of doctors acted with the delegated authority of the State itself. The Royal Society of Physicians held a charter from the English Crown which conferred upon it the right to license, to discipline its own members, to search for and to seize illegal drugs, and otherwise as a corporate body to secure the common health. When, much later, Congress issued a charter to the Medical Society of the District of Columbia, it described its rights and obligations in words almost identical with the charter of the Royal Society. However, it was careful to withhold from the new medical society all economic power over its members. It refused to confer upon it authority to fix any schedule of fees for service. And, to clinch the matter, it stated that the privilege accorded was for scientific and educational work and for "no other purpose" whatever.

The same legal recognition of the public interest marked the law which converged on the case. The American Medical Association, or rather its attorneys, argued at one time that medicine was not a trade; hence doctors, even as officers of an association, could not be guilty of restraint of trade. And at another time they claimed for the American Medical Association the immunities from antitrust which by acts of Congress have been accorded to the labor unions.

If, as the Journal of the American Medical Association insisted, it was an insult to call medicine a trade, it is a little hard to see how dignity could be restored by calling its association a trade union. The freedom accorded the unions was intended to make possible collective bargaining with their employers, while here a collective bargain between physicians and their patients is just the thing the American Medical Association stood against.

But, just to get the record straight, never once in all the proceedings did the Department of Justice call medicine a trade. Instead, it lodged against the American Medical Association the charge of restraint of trade. Now, restraint of trade, like a hundred glib medical phrases, is a term of art; you can, no more than with a bit of medical nomenclature, discover its meaning by looking up its verbal parts in the dictionary. As irony would have it, it is medicine more largely than any other calling which has given us this rule against restraint of trade. A doctor sells his practice to another doctor. He covenants that for a period of 9 years and within a distance of 25 miles he will not engage in practice. For a reasonable time, say 2 years, he endures his idleness. But the itch to be up and at it grows, and sooner or later the old shingle is hung out. Then the other doctor, who has laid out good cash, becomes indignant, demands what he paid for, and calls for justice. The doctor who found it is not healthy to rust has his ready defense. Society needs his services. His contract is in restraint of trade, hence it is void as against public policy.

Sometimes the plaintiff wins, more often the defendant, but always the court pits the common health against private advantage. His service is of such public importance that a physician is not allowed by his own will and to his own advantage to swear away his right to practice. We were able to present more than 100 cases in which the rule against restraint of trade was applied to medicine. The rule emerged, in fact, very largely out of actions of doctor versus doctor.

With the victory of the Government in the Supreme Court the case is now closed. I advert to it only because it has current significance. It is, to borrow a term from your profession, a symptom of a pathological condition in the organization of medicine. The organization of medicine has not kept up with its technology. The fault is not individual, but institutional. The cleavage is not to be eradicated by invectives, by isolation from modern thought, by clinging stubbornly to that which was once good. It can be resolved only by an escape from folk lore, a probing diagnosis, a conquest of prejudice, a drive at the very heart of the malady.

Let us briefly survey the great trends which converge upon medicine, for they decree a revision of means if the great ends of the Hippocratic oath are to be served.

First, the art of medicine has refused to stand still. The family doctor, with his bedside manner, his nostrums, his ponderous vocabulary to conceal his perplexities, his downright devotion to duty and sacrifice of self, was once the very epitome of the art of healing. He has been succeeded by the general practitioner who is the focus of a group of specialists, of which there are now more than a score, each with what a lawyer would call its own jurisdiction. The doctor's office, filled with gadgets and contraptions, has become a combination of consulting room, laboratory, and miniature hospital. A number of separate shops for X-rays, chemical tests, and pathological checkups have become necessary adjuncts. Access to a hospital has become a requirement of the individual physician. Consultation with his fellows has grown into an essential of practice. And behind all this is medicine which, as science and art, is on the march. Behind medicine stand optics, physics, chemistry, biology, and bacteriology, and still medicine continues to capture provinces which until recently lay beyond its frontiers.

Second, the community which the physician must serve has changed with the times. In the good old days the parson, the squire, and the doctor each held sway over his flock. Allegiance to the family doctor was a tie so firmly rooted that it took a crisis to break it. But our world no longer invites so durable, so personal, so exclusive a relationship. The machine, the corporation, and the pecuniary calculus have made over our work, our lives, our personal relationships. Our society has become urban, industrial, gregarious. We have become a new sort of wanderers, a race of modern nomads operating a material culture.

For most of us a job has come to replace an equity in the old homestead. For most of us livings, no longer taken directly from the farm, are pent in between the wages we receive and the prices we must pay. As individuals we are as stubborn as ever our ancestors were. But we act far less on our own and far more as managers, agents, or employees. Our industry is operated by corporations, our farmers band themselves into cooperatives, our workers, skilled and unskilled, gather into unions, even the great mass of our scientists make their discoveries while working for others. In our culture the group has come to be the regular thing.

Against such forces our minds cannot stand firm. Profound changes in habit, interest, and value have come in their wake. The standard of living has moved to a place of primacy among our everyday concerns. It makes the costs of medical service an inescapable problem. The care of the sick no longer can be absorbed by the family; it becomes an item of expense in the budget. If it is a wage earner who is ill, there is a double cost; absence from work means

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loss of earnings and bills are there to be paid. So medical service becomes a sheer economic necessity, for unless a man's capacity to work is maintained, he ceases to earn. Health thus becomes an aspect of the operation of the national economy.

Within this urban, industrial, wage-earning society, men and women are becoming increasingly conscious of what they want. Our workers demand health as a condition of their livelihoods. They insist upon adequate medical service at a price they can afford to pay, and in their newly-won self-respect they will refuse all charity.

Third, a changing medicine has not yet been adapted to its new world. The high objectives of the profession endure, for they are eternal. But they must be freshly applied. Our society cannot be served by an instrument designed to fit the family physician into the village community. Neither my time nor your patience will permit a prolonged analysis. Yet two or three soundings will reveal the nature and contours of a very insistent problem.

In the not so long ago the old-fashioned doctor could be depended upon to administer medicine for the community. He could see to it that needs were met, service was adequate, and costs were justly distributed. The physician of today is in no position to discharge this office. His practice comprehends, not the whole community, but a mere fraction of it. If he is a specialist, the fraction is highly selective. And the whole body of physicians, each operating by himself, has no collective instrument by which it can apportion the totality of service in accordance with general need. Nor can it any longer take the specific responsibility of graduated charges. The sliding scale survives as a legacy from a simpler society and it has not yet been shaped to the circumstances of modern life. In the larger cities and even in smaller places, there is something of a trend toward fashionable, middle-class, or industrial-worker practice. Here obviously the sliding scale no longer operates, for different physicians serve persons in different income groups.

It is far more serious that charges as a whole are quite out of accord with the ordinary standard of living. As medicine has advanced, its arts have become more intricate. Yet very little attention has been given toward making up-to-date facilities available at prices the common people can afford to pay. It is not that on the whole physicians are paid too much; the statistics I have seen lead me to believe that their remuneration is quite inadequate. It is rather that there is waste, a failure fully to use facilities, a lack in getting the most out of a trained personnel.

The result is a national tragedy. The rich, who do not have to consider price, are often pampered with medical care which they may not need. Paupers are often indulged with a service which rises far above their ordinary way of life. The great middle class finds charges

on the whole quite above its ability to pay. As a result, a great part of our population tries to reduce its demand for medical service to the minimum. A great volume of cases reach the doctors in an aggravated condition which, in an early stage, could have been easily handled. Necessary service is often secured at the cost of a heavy debt—a fact which does not make for health. And a far larger part of the people than I like to admit never become your patients.

Here then is challenge. The arts of medicine have advanced; the importance of medicine has been enhanced; it has become a necessity to the people and an essential in the operation of the industrial system. It has outgrown the organization into which, in days of petty trade, it was cast. The demand is for a vaster, more comprehensive, more reliable medical service. If an instrument of the common health can be provided on terms the people can afford, the people will rejoice. If you do not help them to it, the people will seize upon whatever agencies are at hand as a help in time of need, for the universal demand that the common health be served cannot much longer be stayed.

A new medical order is inevitable. Whether we shall cling to the old order or create a new one is not the question. The swift course of events has decreed that there can be no turning back. The question is rather what sort of a medical order it is going to be and whether it is the best which wisdom and knowledge can contrive. Like every promising venture, it has its hazards. Is it to be shaped by the best understanding which law, medicine, and the social studies can bring to it? Or is it to be constructed by amateurs in ignorance but with good intentions?

I can understand how, in the face of a new venture, you wonder whether change may not fail to constitute progress. I am certain that there will be serious loss if you sit upon the side lines and allow whoever may come to power to shape this new medical order.

As medicine gropes for a new organization, we all hear much of the doubts and fears of the profession. Many doctors are fearful lest objectives which have been hard won and which they value highly be lost. Many do not see how things which to them are essential can be fitted into a new order. Let us consider a few of the current perplexities.

A great many physicians are justly fearful that the quality of service may be compromised. From the profession I have frequently heard the argument that, when the Government undertakes to look after the health of the people, the service rendered is invariably poor. With this insistence on quality I fully concur. Nor do I dispute the fact that the new venture may provide a service that fails to meet the standards of the profession. But I cannot follow the argument that a causal relation exists between Government auspices and poor medi-

cine. The truth is that the new system will bring medical care to hosts of people who before have had no access to it. For them there can be no falling off in quality: there has been no service to fall off in quality. Under a new system the provision of doctors and facilities almost always falls short of the new and enlarged demand. As a result, doctors with exacting notions discover much with which they can find fault.

But let us be fair and place the blame where it belongs. The shortcomings are not necessarily due to the new system. They are probably due to the shortage of personnel and equipment with which to work. It is hardly wise to blame untried arrangements, when there is a scarcity of doctors, nurses, clinical facilities, and drugs. No system can discharge its obligations if it lacks the men and materials with which to carry on.

Much is said, too, about the maintenance of a "personal relation" between doctor and patient. Like the law, medicine is practiced by persons and is practiced upon persons. The patient may be served by one or a number of physicians; the contact may endure for a single call, over a stretch of time, or for a long period of years. But in the practice of the profession, there is no escape from a personal relationship. The law has made this clear beyond a reasonable doubt. Not so long ago a declaratory judgment was sought in the District of Columbia against Group Health Association. The action was brought in behalf of the Medical Society, which argued that a corporation could not legally engage in the practice of medicine. The court replied that medicine can only be practiced by physicians and that Group Health, a corporation, did no more than furnish the auspices under which doctor and patient were brought together. Whatever the character of the organization, the relation is in essence personal.

An oft-repeated variant of the same theme is the insistence upon the right of the patient freely to choose his physician. As a patient I am quite willing to have this right qualified for my own good. A well-recognized principle of economics has it that freedom of choice should be limited where the consumer is not a proper judge of the quality of the ware. If there is one field where freedom of choice should be qualified, it is medicine. For medicine is not one thing but many things. Its services are of a highly technical character. If we are downright honest, you and I know that the layman possesses neither the facts about the distinctive competence of particular physicians nor trustworthy norms to guide his judgment. In a matter of medicine, I am not foolish enough to trust my own choice, and a check with some of my lawyer colleagues indicates that they agree with me. I have over the years, through the devious ways by which a layman gets a little practical knowledge, discovered a physician or

two whose judgment I have reason to trust. And with me it is their choice, not mine, which goes.

How many patients have walked into your office whose ailments have been aggravated by an amateur's choice of a physician? If for a moment I can be quite rash, I venture to say that in medicine competence does not wholly accord with ability to attract patients, as in law it does not always rest on ability to attract clients. List, if you will, the six physicians in your city in which you repose the greatest confidence. Let me, from the records of the Bureau of Internal Revenue, list the six who have the highest incomes. It's dollars to doughnuts, isn't it, that the lists do not match? People go to Johns Hopkins or the Mayo Clinic not to be treated by a particular doctor, but to secure skillful service. A personal choice, for that matter, can be secured even under State medicine. But far more important to the patient is the assurance of a high standard of competence.

Nor is wide-open freedom fair to the physician. He should on sheer merit advance in his profession. In all justice his work should be judged, not by the laity, to whom medicine is still a mystery, but by men of his craft who can distinguish brilliant from routine work. "The free choice of a physician," I fear, has become a shibboleth which will not stand analysis.

Candor compels me to say that I feel much the same about the argument that group practice robs the physician of his incentive. In its usual form it runs that if a man is on his own, he will give his best; if he works for a salary, he will put in his hours and let it go at that. The age-old traditions of your honorable profession deny the truth of such an argument. Your code of medical ethics has always elevated the relief of suffering above the pursuit of gain. Its purpose has always been to save the physician from avarice, one of the seven deadly sins. It has long been a canon of yours that service is to be given to rich and poor alike, that quality is not to be tempered to the ability of the patient to pay. My limited experience indicates—and a number of colleagues to whom I have put the question concur—that the mightiest urge to which the physician responds is the pride, the drive, the keeping faith with his calling. A doctor cares, and cares mightily, about the respect of his fellows. A friend of mine tells me of his oculist who insisted he should stop in Baltimore and consult an oculist there. My friend, professing himself satisfied, saw no occasion for the consultation. Finally the oculist said, "Do I have to be brutally frank? I'm damn proud of that operation on your left eye; Dr. Blank is my old teacher, and I want an excuse for him to take a peek at my work." You know better than I that a conscientious and resourceful physician is not, if he can help it, going to

allow a case to lick him, and if the case is tough and he loses, it hurts.

Now I do not say that material things are to the doctor of no account. Like the judge, the lawyer, the engineer, the university professor, he has a right to demand advancement, security, an income adequate to his standard of life. For the professional man such things are necessities. Without them the physician is not in a position to give his best.

But such values depend upon no one single way of organizing medicine. To say that a doctor will give his utmost if he acts as his own business agent, and that his incentive will be stifled if he receives a salary, is not borne out by experience. The time was when the great scientific advance was the work of the solo inventor. Today the most creative of all work, the progress of science and the useful arts, is the product of men on salary. In the larger offices the great mass of lawyers now work on salary and work as hard and as heroically as the youngster who used to flaunt his own shingle in the breeze. It is true that the chance to become a partner is an incentive, but I would not rank it overly high, for work equally as good is done by the lawyers in the Government, where no such opportunity exists. In our institutions of higher learning, research as well as teaching falls to salaried employees and there you will observe an interest, excitement, devotion to duty, an urge to be up and doing. To return to medicine, how many thousands of our best doctors are today giving their all without stint in the service of the Army and the Navy?

Ambition, security, income are necessary things. They have in every age and among the most varied conditions of society driven men to accomplishment. If I were a youngster, I would rather leave the series of judgments which shape my career to men of my own profession than attempt to get ahead by translating my skills into the art of winning and holding patients. Most important of all, why is it that doctors are troubled by this doubt when university professors, lawyers in public service, officials who make of government a lifework, never even raise the question. And why is it that, when the Government of England first undertook to offer medical service, there was quite a chorus which viewed with alarm the loss of incentive, while today such a doubt remains unvoiced? It is easy enough to answer the argument that a salary will kill the urge to serve; it is hard to understand why the question is ever asked.

It is too late to turn away from that fearful subject of the State as employer, for I am already discussing it. As for myself I have no more fear of a venture of the State into medicine than I have of a venture of the State into law. The venture into law is old—judges, public counsel, prosecuting attorneys, are examples. The venture into medicine, the pauper and the criminal aside, is new, but the traditions and high standards which have long operated in one realm

can be established in the other. Our Federal Government, in most of its activities, has adhered to a very high standard of professional competence. If for a moment I may be personal, I have experienced the practice of law in a large private New York office and in the Department of Justice. The Government has never imposed upon me restrictions which I have felt to be a burden. If anything, I have enjoyed a greater freedom than I could have had in a private law office. It is true that frequently my own judgment is tempered by the opinions of my colleagues. But usually a consultation, as you call it, leads to a sounder decision than any one of us alone would make.

You are right in insisting that high standards of medical care must not be compromised. But standards are a professional matter. Their chief dependence is upon adequacy of resources. They are not inherent in any type of organization. Your current way, as well as State medicine, has its insidious dangers, and, since comparative merits are at issue, I am not content with any argument which points out vices in the one without looking at the faults of the other. As it is now practiced, medicine is exposed to the corroding ways of business. Witness the recent exposure of fee-splitting in the city of New York. Under another dispensation, medicine may be exposed to the strange ways of politics. Which is the greater temptation, I am not able to say. But politics is a thing from which no activity of man is free. It can be employed to achieve holy as well as unholy results. And the State is not, as some of my physician friends seem to fear, a ward heeler telling the doctor how to practice.

I am not, mind you, presenting a case for or against the prevailing system, State medicine, or any particular medical order. There is, as I said at the beginning, no such question as private practice versus socialized medicine. For practice is never private and all medicine has a social function. The question to be faced is harder, more intricate, far more detailed than any such antithesis suggests. First of all you must ask what you want medicine to do. That is easy, to furnish to the whole population an adequate service of quality upon terms it can afford. Next, you must contrive ways and means of seeing to it that the great variety of services we call medicine are called into play to serve the common health. Next, you must set up protections against the hazards you and I see so clearly. And finally, all of these arrangements must be brought together into a going organization. Such a result is not to be attained by an act of faith or a single trial. The conditions of health vary from city to country, from section to section. The needs of the people as locally felt must be met, and this means variety, flexibility, and capacity for adaptation. It means, seek—honestly, objectively, courageously—and ye shall find; knock at many doors until the right ones shall be opened to you.

There is no royal road to a modern medical order. Thus the system we seek is not a choice between private practice and socialized medicine. In following his private calling the physician is fulfilling a social service; in medicine "private" and "social" always have been and always will be associated. These terms, so frequently set down as opposites, have only the most evasive content. Private practice has no stabilized form; the private practice of the country doctor who rode his horse, made his rounds, and was monarch of all he surveyed is not the private practice of a modern urologist. And "socialized medicine" embraces systems as distinct as the charity of the medieval church, the Royal College of Physicians, the clinic of a modern university, the bureau of public health, and the Russian way. You can no more get anywhere with such terms than you can practice your profession with a general concept of disease as your stock in trade.

The question demands, not an easy answer, but painful, constructive, detailed thought. It demands, too, an indulgence in downright trial and error without which nothing worthwhile emerges. A few experiments—far fewer than the length and breadth and depth of the subject demands—have been blazing fresh trails. Increasing numbers of physicians have enjoyed practice on their own and on salary, and are prepared, from experience rather than in speculative terms, to assess debits and credits. In my pocket I have a letter from one such physician who sets down an illuminating comparison by no means to the disadvantage of salaried work.

Last but most important of all, the war has accelerated a trend long in the making. A host of physicians now in service are conscious of the shortcomings of "military medicine" and have scores of suggestions as to how it can be improved. But they have become aware of the tremendous possibilities which inhere in a medicine directly organized to perform its function. Millions of soldiers, returned from the front, are going to demand for themselves and for their families the instruments of health to which they are entitled.

The course of events moves fast and a new medical order seems inevitable. My fear is not that we will not get it; an awakened public, sparked by our veterans, will see to that. My fear is that we will not bring to its creation all the knowledge, wisdom, and understanding we possess. A reference to the Wagner-Murray-Dingell bill will make my point. About its intent and objectives for me there can be no dispute. The detail of its provisions, however, may or may not fall short of its purpose—I do not know. On ways and means I am open to argument in behalf of something which is better. Of the necessity for distributing the cost of protection against illness I am wholly convinced, and I think the American people are adamant.

The medical order our stalwarts defend has already ceased to exist.

A new medical order will come into being even though we do not will it, even, in fact, if we stubbornly resist it. For the medical order, like other institutions, cannot insulate itself against the impinging culture. It must make its response to the great pulsing tides which everywhere else enter our national life. The wiser physicians know that sheer opposition is not going to hold back the tide. They are putting forward—it seems to me a little timidly—proposals of their own. The other day the medical society right here in St. Louis voted approval of a plan for prepaid medical care, and the papers stated that a minority of doctors thought it did not go far enough. Timidity must be replaced by high resolve, and I am afraid that a very old adage which goes back at least as far as ancient Egypt applies here: "If you can't stop a movement, join it."

Seriously, support of the doctors is essential to the salvation of the movement. The organization of medicine is an affair of a couple of shops. It is a job for the craftsman in social order, but it must be shaped to the very life of the medical service it has to offer. If doctors oppose, or stand on the side lines, the layman will create a medical order which may prove to be indifferent or even blind to the values doctors prize most. If the doctors assume a role in its creation, they can see to it that no compromise is made with the standards of the profession.

The problem thus becomes one of creation. In respect to the selection of personnel, the standards of care, the carrying of risks, the methods of payment, the ways of remuneration a score of ways are open. The form of organization may follow an agency of the State, the university pattern, the hospital set-up, or a combination of devices from all these. The Government may dominate the system, become one of a number of parties to its management, or be excluded from it altogether. The venture may fall into the legal form of a public health authority, a nonprofit-making corporation, a series of independent or interlocking corporations, a group of consumers cooperatives, a mutual association of the profession and the laity, or something else. Its direction may be lodged with a tripartite board, representing the Government, the public, and the profession, or the public and the profession, free from Government interference, may assume joint responsibility. It may or may not be State medicine; it cannot escape being social medicine.

It is man for whom medicine exists. Its function must be to keep a whole people in health. The doctor must be the focus, but upon his office a host of unlike services must converge. The physician must not stop with asking, "Of what is this man ill and what can I do about it?" He must also inquire, "Why and how did this man become ill in the way he did?" The quest leads beyond cure to all

the conditions upon which personal well-being depends. Food, clothing, housing, recreation, family, occupation, social life are all terms in the equation of health. Nor must man's habitat be forgotten, for adaptation is a requisite of the life process. Many arts must converge into the new medicine; prevention, sanitation, the public health must become a part of it. At its hub must stand the doctor; it is he who must direct this vast apparatus of skills, specialized personnel, facilities to the service of the human being. The medical order I suggest, and which the American people are going to have, will be vaster and mightier than anything we now know.

Such a medical order, it seems to me, should be hailed enthusiastically by the physician. In respect to professional matters his word will prevail. His opportunities for service will be greatly enlarged. He will have access to facilities which only the exceptional physician can now afford. A shift in work now and then will keep him alive in his profession. He can get away occasionally for further training. And above all, he ought to be better able to turn his clinical work to permanent account.

In an abstract way I recognize the value of ivory-tower research. But, after all, the heat of the daily round has its own contribution to make. In our Antitrust Division we have in the last 5 years perhaps done more to blaze a path for the law than any law college faculty in the land. The result has not been due to any unusual ability of ours. We have simply been on the firing line and have had an opportunity to turn our clinical work to account. To me it seems that one of the great shortcomings of the prevailing medical system is that the practitioner is kept so busy with his patients that he cannot translate his work into medical discovery.

Thus, in the end, I return to my beginning. I can hand you no ready-made medical order on a silver platter. If I could, it would do you no good. I can only suggest to you, whose minds have long been busied with the subject, some reflections of a man of another profession. And I am positive that a service adequate to the times cannot be brought into being without the doctors' creative participation. As doctors and patients we face a crisis, and my appeal is to the ancient wisdom of the profession. The ends of medicine remain unchanged; ways and means must be found to adapt its practice to the conditions of present-day society. A new organization must be created that an ancient mission be not lost, that once again medicine shall be available to all in need and charges shall be graduated in accordance with ability to pay.

An instrument of the common health such as never before has been offered to a people is within our reach. This is no time for petty doubts and timid moves. In the face of a national challenge we must, as one of our great jurists said of the law, let our minds be bold.

TULAREMIA: SPONTANEOUS OCCURRENCE IN THE CHIPMUNK [1]

By R. R. PARKER, *Director, Rocky Mountain Laboratory, United States Public Health Service*

The recovery of *Pasteurella tularensis* from a chipmunk, *Eutamias* sp., adds this rodent to the already long list of animals of our native fauna in which tularemia occurs spontaneously.

The chipmunk from which the isolation was made had been captured alive in June 1939 at a summer camp on Mica Bay, Lake Coeur d'Alene, Kootenai County, northern Idaho. It died two days later and the carcass was forwarded to the Rocky Mountain Laboratory. The isolation of the bacterium was made from the heart blood, taken just before death, of two guinea pigs that were injected with a pooled suspension of spleen, liver, and lung tissue.

INCIDENCE OF HOSPITALIZATION, NOVEMBER 1944

Through the cooperation of the Hospital Service Plan Commission of the American Hospital Association, data on hospital admissions among members of Blue Cross Hospital Service Plans are presented monthly. These plans provide prepaid hospital service. The data cover hospital service plans scattered throughout the country, mostly in large cities.

Item	November	
	1943	1944
1. Number of plans supplying data	68	76
2. Number of persons eligible for hospital care	11,478,284	15,560,515
3. Number of persons admitted for hospital care	94,495	129,388
4. Incidence per 1,000 persons, annual rate, during current month (daily rate × 365)	100.2	101.4
5. Incidence per 1,000 persons, annual rate for the 12 months ending November 30	105.1	103.9

DEATHS DURING WEEK ENDED DECEMBER 9, 1944

[From the Weekly Mortality Index, issued by the Bureau of the Census, Department of Commerce]

	Week ended Dec. 9, 1944	Corresponding week, 1943
Data for 92 large cities of the United States:		
Total deaths	9,313	10,419
Average for 3 prior years	9,449	
Total deaths, first 49 weeks of year	438,941	447,984
Deaths under 1 year of age	594	657
Average for 3 prior years	653	
Deaths under 1 year of age, first 49 weeks of year	30,227	32,240
Data from industrial insurance companies:		
Policies in force	66,920,488	66,093,574
Number of death claims	14,326	12,621
Death claims per 1,000 policies in force, annual rate	11.2	10.0
Death claims per 1,000 policies, first 49 weeks of year, annual rate	10.1	9.6

[1] From the Rocky Mountain Laboratory of the Division of Infectious Diseases, National Institute of Health.

PREVALENCE OF DISEASE

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

REPORTS FROM STATES FOR WEEK ENDED DECEMBER 16, 1944

Summary

A total of 201 cases of meningococcus meningitis was reported, as compared with 190 last week, 50 for the 5-year (1939–43) median, and 281 for the corresponding week last year. Of the current total, 110 cases occurred in the 6 States reporting more than 9 cases each as follows (last week's figures in parentheses): New York 30 (26), New Jersey 16 (7), Pennsylvania 15 (17), Ohio 12 (9), Illinois 13 (12), California 24 (14). In the 14 weeks since September 9, the week of lowest incidence this year, a total of 2,208 cases has been reported. For the same period last year the number was 3,076, and for the comparable 5-year median, 449. The cumulative total to date is 15,689, as compared with 17,098 last year, and a 5-year median of 1,958.

For the first time since June 26, the weekly incidence of poliomyelitis fell below that of the corresponding week last year. A total of 85 cases was reported, as compared with 133 last week, 89 for the corresponding week last year, and a 5-year median of 78. The only States reporting more than 4 cases were New York (27) and Nebraska (15). A total of 19,104 cases has been reported for the year to date, as compared with 12,319 for the corresponding 50 weeks last year, and 8,962 for the corresponding 5-year median.

The weekly incidence of diphtheria since September has continued somewhat above that of last year, although, for the most part, below the 5-year median. The figure for the current week is 416, as compared with 295 for the corresponding week last year and a 5-year median of 393.

A current total of 3,860 cases of scarlet fever was reported, as compared with a 5-year median of 3,100, and 3,829 in 1939, the latter being the largest number reported for a corresponding week of the preceding 5 years. The current incidence of influenza, 2,924 cases, is below corresponding figures for all of the past 5 years except 1942. The total of 766 cases of measles for the week is less than one-sixth of the corresponding 5-year median.

Deaths registered for the week in 92 large cities of the United States totaled 9,311, as compared with 9,373 for the preceding week and a 3-year average of 9,975. The cumulative total to date is 447,238, as compared with 458,555 for the corresponding period last year.

Telegraphic morbidity reports from State health officers for the week ended December 16, 1944, and comparison with corresponding week of 1943 and 5-year median

In these tables a zero indicates a definite report, while leaders imply that, although none was reported, cases may have occurred.

Division and State	Diphtheria			Influenza			Measles			Meningitis, meningococcus		
	Week ended—		Median 1939–43	Week ended—		Median 1939–43	Week ended—		Median 1939–43	Week ended—		Median 1939–43
	Dec. 16, 1944	Dec. 18, 1943		Dec. 16, 1944	Dec. 18, 1943		Dec. 16, 1944	Dec. 18, 1943		Dec. 16, 1944	Dec. 18, 1943	
NEW ENGLAND												
Maine	0	3	0	------	88	1	3	104	93	1	4	1
New Hampshire	0	0	0	------	2	------	1	2	2	0	0	0
Vermont	0	0	0	4	------	------	4	0	21	0	3	0
Massachusetts	5	5	5	------	------	------	58	245	302	7	8	2
Rhode Island	1	1	1	22	35	------	3	81	19	0	4	0
Connecticut	0	0	0	2	219	5	11	8	60	0	4	2
MIDDLE ATLANTIC												
New York	14	25	21	(1)	[1] 357	20	37	531	531	30	47	5
New Jersey	9	4	6	6	163	13	10	321	40	16	14	1
Pennsylvania	8	15	14	3	44	------	42	506	723	15	20	7
EAST NORTH CENTRAL												
Ohio	9	11	13	10	2,625	23	12	1,180	53	12	7	2
Indiana	10	1	3	3	1,469	26	3	139	21	3	1	1
Illinois	4	4	22	5	416	14	34	166	83	13	31	2
Michigan [2]	22	5	6	1	148	9	19	535	391	9	16	2
Wisconsin	2	0	0	6	962	44	0	504	227	9	12	1
WEST NORTH CENTRAL												
Minnesota	10	8	2	1	185	1	6	549	66	0	4	0
Iowa	8	1	3	------	4,002	1	13	44	44	0	0	0
Missouri	1	5	11	3	149	4	8	15	7	7	18	1
North Dakota	28	2	1	2	1,141	28	0	164	2	1	0	0
South Dakota	2	2	2	------	25	------	3	66	7	1	0	0
Nebraska	11	0	2	17	349	3	12	15	8	0	1	0
Kansas	10	1	4	4	788	27	7	19	71	2	3	1
SOUTH ATLANTIC												
Delaware	1	0	0	------	4	------	4	11	3	0	1	1
Maryland [2]	5	3	9	2	218	10	1	30	11	6	6	1
District of Columbia	0	1	0	1	1,349	2	3	36	2	0	4	0
Virginia	4	8	23	208	9,349	233	1	636	94	3	8	2
West Virginia	5	4	8	8	2,062	27	22	91	9	0	2	2
North Carolina	14	10	35	6	119	11	16	239	239	2	3	1
South Carolina	1	7	7	362	1,498	460	3	69	10	2	4	0
Georgia	13	7	14	58	1,219	214	21	77	22	1	2	0
Florida	4	2	8	1	102	11	3	19	3	4	1	0
EAST SOUTH CENTRAL												
Kentucky	2	3	10	------	34,148	13	0	10	13	2	2	2
Tennessee	10	10	10	27	391	52	12	25	25	3	6	1
Alabama	14	17	22	53	886	112	1	150	35	1	5	1
Mississippi [2]	22	4	13	------	------	------	------	------	------	4	3	1
WEST SOUTH CENTRAL												
Arkansas	5	6	16	57	2,663	150	5	36	23	2	2	1
Louisiana	10	9	9	3	58	9	5	8	3	1	1	1
Oklahoma	16	9	9	137	999	91	6	8	10	4	0	1
Texas	58	49	49	1,702	5,309	873	51	99	47	6	2	2
MOUNTAIN												
Montana	2	1	1	19	2,468	60	1	112	28	0	1	0
Idaho	0	0	0	1	4	4	0	3	11	0	0	0
Wyoming	0	0	0	27	227	148	4	8	8	0	0	0
Colorado	5	3	7	4	820	54	9	192	154	3	1	1
New Mexico	2	4	3	2	124	1	0	3	3	0	3	1
Arizona	2	2	2	109	1,106	110	5	21	21	2	1	0
Utah [2]	0	0	1	8	1,205	610	9	4	45	1	3	0
Nevada	0	0	0	------	21	------	1	1	0	0	0	0
PACIFIC												
Washington	35	15	7	------	1,490	12	34	52	52	3	6	2
Oregon	9	5	2	21	760	176	26	55	55	1	3	1
California	23	23	19	19	1.185	84	237	126	120	24	14	3
Total	416	295	393	2,924	82,951	6,465	766	7,315	4,779	201	281	50
50 weeks	13,411	13,255	15,132	361,685	209,594	209,594	600,816	587,903	496,067	15,689	17,098	1,958

[1] New York City only.

[2] Period ended earlier than Saturday.

Telegraphic morbidity reports from State health officers for the week ended December 16, 1944, and comparison with corresponding week of 1943 and 5-year median—Con.

Division and State	Poliomyelitis			Scarlet fever			Smallpox			Typhoid and paratyphoid fever[1]		
	Week ended—		Median 1939–43	Week ended—		Median 1939–43	Week ended—		Median 1939–43	Week ended—		Median 1939–43
	Dec. 16, 1944	Dec. 18, 1943		Dec. 16, 1944	Dec. 18, 1943		Dec. 16, 1944	Dec. 18, 1943		Dec. 16, 1944	Dec. 18, 1943	
NEW ENGLAND												
Maine	0	1	0	52	25	12	0	0	0	1	2	1
New Hampshire	0	0	0	27	5	3	0	0	0	1	2	0
Vermont	0	1	0	5	2	2	0	0	0	0	2	1
Massachusetts	0	3	1	251	193	193	0	0	0	4	1	3
Rhode Island	0	0	0	22	2	10	0	0	0	0	0	0
Connecticut	0	2	0	55	58	45	0	0	0	0	0	1
MIDDLE ATLANTIC												
New York	27	8	8	333	286	301	0	0	0	5	8	6
New Jersey	2	1	1	88	85	122	0	0	0	1	1	1
Pennsylvania	1	5	2	250	160	226	0	0	0	0	4	6
EAST NORTH CENTRAL												
Ohio	4	1	1	318	250	228	0	0	0	0	3	3
Indiana	0	0	0	76	40	87	0	1	1	0	0	2
Illinois	1	2	2	268	150	207	0	0	1	2	2	3
Michigan[2]	4	0	1	189	151	185	0	1	1	1	6	3
Wisconsin	2	0	0	128	135	149	0	0	1	0	1	1
WEST NORTH CENTRAL												
Minnesota	1	0	2	60	120	92	0	0	0	0	0	0
Iowa	1	1	1	68	55	55	0	1	1	0	2	1
Missouri	1	2	1	70	48	52	0	0	0	0	1	1
North Dakota	1	0	0	24	14	14	1	0	0	0	0	0
South Dakota	0	1	1	16	34	33	0	0	0	1	0	0
Nebraska	15	1	1	56	38	30	0	1	1	0	0	0
Kansas	1	4	2	94	101	70	2	0	0	0	0	0
SOUTH ATLANTIC												
Delaware	0	0	0	11	3	11	0	0	0	0	0	0
Maryland[2]	1	1	0	88	43	47	0	0	0	9	0	2
District of Columbia	1	0	0	49	27	12	0	0	0	2	1	1
Virginia	3	0	0	70	38	45	0	0	0	0	0	5
West Virginia	0	0	1	39	58	52	0	0	0	0	0	1
North Carolina	1	0	2	63	72	78	0	1	1	0	0	3
South Carolina	0	0	1	15	12	12	0	0	0	1	0	1
Georgia	1	0	0	32	29	35	0	0	0	5	5	4
Florida	1	1	1	8	7	7	0	0	0	1	2	2
EAST SOUTH CENTRAL												
Kentucky	2	6	1	72	45	76	1	1	0	0	4	4
Tennessee	0	0	0	89	47	60	0	0	0	2	3	1
Alabama	0	0	0	20	10	23	0	1	0	0	2	1
Mississippi[2]	0	1	1	23	4	11	0	0	0	2	0	1
WEST SOUTH CENTRAL												
Arkansas	2	1	0	17	11	11	0	0	0	1	2	2
Louisiana	0	1	0	21	8	7	2	1	0	3	4	4
Oklahoma	0	1	1	26	22	22	0	0	2	1	1	3
Texas	2	3	1	118	52	54	0	3	2	7	4	6
MOUNTAIN												
Montana	0	0	0	19	48	24	0	0	0	0	0	0
Idaho	0	0	0	27	40	13	0	0	0	0	1	1
Wyoming	1	0	0	12	6	8	0	0	0	0	0	0
Colorado	0	0	0	53	31	31	0	0	0	0	0	1
New Mexico	0	2	1	26	5	8	0	0	0	1	1	2
Arizona	0	1	1	7	14	5	0	0	0	2	0	0
Utah[2]	1	8	1	32	94	26	0	0	0	1	0	0
Nevada	0	0	0	5	0	0	0	0	0	0	1	0
PACIFIC												
Washington	4	0	3	87	114	37	0	0	0	0	0	0
Oregon	0	14	1	38	52	19	0	0	0	0	0	0
California	4	16	7	343	171	136	0	0	0	2	4	4
Total	85	89	78	3,860	3,015	3,100	6	11	14	56	70	105
50 weeks	19,104	12,319	8,962	183,195	134,742	134,742	377	724	1,332	5,303	5,376	8,344

[1] Period ended earlier than Saturday.

[2] Including paratyphoid fever reported separately, as follows: Maine, 1; Massachusetts, 2; New York, 1; Michigan, 1; Georgia, 5; California, 2.

Telegraphic morbidity reports from State health officers for the week ended December 16, 1944, and comparison with corresponding week of 1943 and 5-year median—Con.

Division and State	Whooping cough			Week ended December 16, 1944								
	Week ended—				Dysentery			Encephalitis, infectious	Leprosy	Rocky Mt. spotted fever	Tularemia	Typhus fever
	Dec. 16, 1944	Dec. 18, 1943	Median 1939–43	Anthrax	Amebic	Bacillary	Unspecified					
NEW ENGLAND												
Maine	33	6	39	0	0	0	0	0	0	0	0	0
New Hampshire	11	0	8	0	0	0	0	0	0	0	0	0
Vermont	30	10	10	0	0	0	0	0	0	0	0	0
Massachusetts	100	70	199	0	0	2	0	0	0	0	0	1
Rhode Island	17	6	34	0	0	0	0	0	0	0	0	0
Connecticut	98	19	80	0	0	4	0	0	0	0	1	0
MIDDLE ATLANTIC												
New York	286	196	410	0	2	35	0	0	0	0	0	2
New Jersey	118	49	152	0	4	0	0	0	0	0	1	0
Pennsylvania	116	99	295	0	0	0	0	1	0	0	0	0
EAST NORTH CENTRAL												
Ohio	105	66	205	0	0	0	0	0	0	0	6	2
Indiana	3	14	16	0	0	0	0	0	0	0	6	0
Illinois	70	52	162	0	1	0	0	0	0	0	15	0
Michigan [2]	71	128	232	0	0	3	0	0	0	0	0	1
Wisconsin	70	177	186	0	2	0	0	0	0	0	2	0
WEST NORTH CENTRAL												
Minnesota	20	28	67	0	3	0	0	0	0	0	0	0
Iowa	11	19	17	0	0	0	0	0	0	0	0	0
Missouri	14	12	20	0	0	0	1	0	0	0	4	0
North Dakota	5	6	11	0	0	0	0	0	0	0	0	0
South Dakota	0	5	3	0	0	0	0	0	0	0	0	0
Nebraska	4	13	12	0	0	0	0	0	0	0	0	0
Kansas	31	16	33	0	0	0	0	0	0	0	2	0
SOUTH ATLANTIC												
Delaware	4	8	6	0	0	0	0	0	0	0	0	0
Maryland [2]	75	46	71	0	0	0	0	0	0	0	0	0
District of Columbia	3	1	10	0	0	0	0	0	0	0	0	0
Virginia	76	100	43	0	0	0	188	0	0	0	1	1
West Virginia	4	43	35	0	0	0	0	0	0	0	0	0
North Carolina	89	117	117	0	0	0	0	0	0	0	0	5
South Carolina	22	95	29	0	0	4	0	0	0	0	0	13
Georgia	2	9	9	0	1	2	0	0	0	0	5	32
Florida	11	22	10	0	6	0	0	0	0	0	0	16
EAST SOUTH CENTRAL												
Kentucky	10	68	68	0	0	0	0	0	0	0	8	0
Tennessee	10	23	23	0	0	0	1	0	0	0	1	5
Alabama	6	15	21	0	0	0	0	0	0	0	0	14
Mississippi [2]	----	----	----	0	0	0	0	0	0	0	3	8
WEST SOUTH CENTRAL												
Arkansas	14	17	17	0	0	13	0	0	0	0	0	0
Louisiana	2	5	4	0	2	0	0	0	0	0	0	6
Oklahoma	8	3	4	0	0	4	0	0	0	0	0	0
Texas	177	126	126	0	6	419	26	0	0	0	0	27
MOUNTAIN												
Montana	14	3	10	0	0	25	0	0	0	0	0	0
Idaho	3	1	3	0	0	0	0	0	0	0	0	0
Wyoming	8	6	6	0	0	0	0	0	0	0	0	0
Colorado	10	31	31	0	0	0	0	0	0	0	0	0
New Mexico	1	11	16	0	2	3	3	0	0	0	0	0
Arizona	10	16	11	0	0	0	10	0	0	0	0	0
Utah [2]	10	19	23	0	0	0	0	0	0	0	0	0
Nevada	0	0	0	0	0	0	0	0	0	0	0	0
PACIFIC												
Washington	17	64	64	0	0	0	1	0	0	0	0	0
Oregon	16	30	30	0	0	0	0	0	0	0	0	0
California	108	83	151	0	2	9	0	2	0	0	0	1
Total	1,923	1,953	3,360	0	31	523	230	3	0	0	55	134
Same week, 1943	1,953	----	----	2	28	463	51	9	0	0	19	89
Same week, 1942	3,360	----	----	2	14	124	38	7	1	0	28	76
50 weeks, 1944	92,499	----	----	40	1,798	23,874	8,880	619	32	453	633	5,153
50 weeks, 1943	173,808	----	----	65	2,078	17,562	7,344	669	29	433	772	4,393
50 weeks, 1942	172,829	----	[4] 172,829	78	1,171	11,882	6,362	549	45	[4] 451	858	[4] 2,855

[2] Period ended earlier than Saturday.
[4] 5-year median, 1939–43.

WEEKLY REPORTS FROM CITIES

City reports for week ended December 9, 1944

This table lists the reports from 85 cities of more than 10,000 population distributed throughout the United States, and represents a cross section of the current urban incidence of the diseases included in the table.

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
NEW ENGLAND												
Maine:												
Portland	0	0	0	0	0	1	1	0	5	0	1	0
New Hampshire:												
Concord	0	0	0	0	0	0	1	0	3	0	0	0
Massachusetts:												
Boston	5	0	0	0	31	5	12	1	51	0	0	21
Fall River	0	0	0	0	2	1	2	0	1	0	0	3
Springfield	0	0	0	0	0	0	0	0	9	0	0	0
Worcester	0	0	0	0	2	1	6	0	8	0	0	14
Rhode Island:												
Providence	0	0	2	0	0	0	1	0	9	0	0	6
Connecticut:												
Bridgeport	0	0	0	0	0	0	0	0	4	0	0	0
Hartford	0	0	0	0	2	0	0	0	2	0	0	5
New Haven	0	0	0	0	0	1	2	0	4	0	0	32
MIDDLE ATLANTIC												
New York:												
Buffalo	1	0	0	0	2	1	3	1	1	0	0	0
New York	6	1	2	1	6	15	59	13	161	0	3	122
Rochester	0	0	0	0	20	1	6	4	3	0	1	41
Syracuse	0	0	0	0	0	0	3	0	9	0	0	12
New Jersey:												
Camden	1	0	1	1	0	0	1	0	0	0	0	2
Newark	0	0	0	0	1	2	2	0	12	0	0	3
Trenton	0	0	0	0	1	1	2	0	4	0	0	0
Pennsylvania:												
Philadelphia	3	0	3	2	7	4	22	1	54	0	0	33
Pittsburgh	3	0	3	3	2	2	10	0	20	0	0	10
Reading	0	0	0	0	2	0	3	0	1	0	0	1
EAST NORTH CENTRAL												
Ohio:												
Cincinnati	3	0	0	0	0	4	8	0	13	0	0	5
Cleveland	3	0	6	3	2	5	14	4	43	0	0	28
Columbus	0	0	4	4	1	0	5	0	3	0	1	7
Indiana:												
Fort Wayne	0	0	0	0	0	1	2	0	6	0	0	0
Indianapolis	3	0	0	2	2	1	9	0	31	0	0	5
South Bend	0	0	0	0	0	0	0	0	2	0	0	2
Terre Haute	0	0	0	0	0	0	3	0	2	0	0	1
Illinois:												
Chicago	2	0	3	1	8	12	24	0	87	0	0	37
Springfield	0	0	0	0	3	0	2	0	7	0	0	0
Michigan:												
Detroit	11	1	1	0	6	1	12	0	56	0	0	20
Flint	0	0	0	0	0	0	2	0	3	0	0	1
Grand Rapids	0	0	0	2	0	0	0	0	7	0	0	1
Wisconsin:												
Kenosha	0	0	0	0	0	0	0	0	1	0	0	13
Milwaukee	0	0	0	0	3	1	0	0	22	0	0	4
Racine	0	0	0	0	0	0	0	0	0	0	0	4
Superior	0	0	0	0	1	0	0	0	2	0	0	0
WEST NORTH CENTRAL												
Minnesota:												
Duluth	1	0	0	0	0	1	2	0	6	0	0	0
Minneapolis	4	0	0	2	1	0	3	0	7	0	0	4
St. Paul	0	0	0	0	0	0	7	0	6	0	0	18
Missouri:												
Kansas City	4	0	0	0	0	1	13	0	4	0	0	0
St. Joseph	0	0	0	0	0	0	0	0	1	0	0	0
St. Louis	0	0	2	2	1	3	10	0	14	0	0	3

City reports for week ended December 9, 1944—Continued

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
WEST NORTH CENTRAL—continued												
Nebraska:												
Omaha	3	0	0	0	6	0	3	0	21	0	0	0
Kansas:												
Topeka	0	0	0	0	1	0	2	0	7	0	0	1
Wichita	0	0	1	0	0	0	2	0	7	0	0	0
SOUTH ATLANTIC												
Delaware:												
Wilmington	0	0	0	0	0	0	2	0	2	0	0	0
Maryland:												
Baltimore	8	0	3	1	1	3	7	0	69	0	1	63
Cumberland	0	0	0	0	0	0	0	0	1	0	0	0
Frederick	0	0	0	0	0	0	0	0	0	0	0	0
District of Columbia:												
Washington	0	0	1	0	3	2	6	1	24	0	0	8
Virginia:												
Lynchburg	0	0	0	0	0	0	0	0	1	0	0	0
Roanoke	0	0	0	0	0	0	0	0	2	0	0	2
West Virginia:												
Charleston	0	0	0	0	0	0	0	0	4	0	0	0
Wheeling	0	0	0	0	1	0	1	0	3	0	0	8
North Carolina:												
Raleigh	0	0	0	0	1	0	1	0	0	0	0	2
Wilmington	2	0	0	0	1	1	1	0	4	0	0	1
Winston-Salem	0	0	0	0	0	0	1	0	2	0	0	0
South Carolina:												
Charleston	0	0	11	1	0	2	0	0	2	0	0	0
Georgia:												
Atlanta	2	0	6	0	0	0	5	0	5	0	0	0
Brunswick	0	0	0	0	0	0	1	0	0	0	0	0
Savannah	0	0	3	1	0	0	0	0	2	0	0	0
Florida:												
Tampa	0	0	0	0	0	0	6	0	0	0	0	0
EAST SOUTH CENTRAL												
Tennessee:												
Memphis	1	0	0	3	24	1	16	0	5	0	0	2
Nashville	0	0	0	0	0	1	5	0	1	0	0	1
Alabama:												
Birmingham	0	0	1	0	0	0	2	0	3	0	0	0
Mobile	1	0	0	2	0	0	1	0	3	0	0	0
WEST SOUTH CENTRAL												
Arkansas:												
Little Rock	0	0	0	0	0	0	1	0	0	0	0	0
Louisiana:												
New Orleans	5	0	1	1	0	0	11	0	7	0	0	0
Texas:												
Dallas	2	0	0	0	1	0	9	0	7	0	0	0
Galveston	1	0	0	0	0	0	1	0	0	0	0	0
Houston	3	0	0	0	0	0	8	1	6	0	0	0
San Antonio	4	0	3	2	1	0	9	0	12	0	0	0
MOUNTAIN												
Montana:												
Billings	0	0	0	0	1	0	1	0	1	0	1	1
Great Falls	0	0	0	0	0	0	2	0	0	0	0	5
Helena	0	0	0	0	0	0	0	0	1	0	0	2
Missoula	0	0	0	0	0	0	1	0	1	0	0	0
Idaho:												
Boise	0	0	0	0	0	0	0	0	0	0	0	0
Colorado:												
Denver	0	0	7	1	2	2	4	0	19	0	0	1
Pueblo	0	0	0	0	0	0	0	0	1	0	0	0
Utah:												
Salt Lake City	0	0	0	0	5	0	0	0	6	0	0	5

City reports for week ended December 9, 1944—Continued

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
PACIFIC												
Washington:												
Seattle	0	0	0	1	5	1	3	0	11	0	0	5
Spokane	0	0	1	0	1	0	2	0	9	0	0	0
California:												
Los Angeles	6	0	20	2	10	0	7	1	54	0	0	11
Sacramento	0	0	1	1	3	0	7	0	10	0	0	0
San Francisco	1	0	3	1	15	0	6	2	25	0	0	4
Total	89	2	96	41	196	80	394	29	1,051	0	9	594
Corresponding week, 1943	70	------	779	76	1,798	------	585	------	1,074	0	15	450
Average, 1939–43	89	------	1,258	[1] 69	[2] 1,044	------	[1] 498	------	856	2	19	950

[1] 3-year average, 1941–43.
[2] 5-year median, 1939–43.

Dysentery, amebic.—Cases: Boston, 1; New York, 3; Los Angeles, 1; San Francisco, 1.
Dysentery, bacillary.—Cases: Providence, 2; Buffalo, 1; New York, 28; Rochester, 3; Syracuse, 3; Newark, 1; Cleveland, 1; Detroit, 1; Charleston, S. C., 1; Nashville, 2; Los Angeles, 4.
Dysentery, unspecified.—Cases: San Antonio, 20.
Tularemia.—Cases: Cincinnati, 2; Fort Wayne, 1; Chicago, 1; St. Louis, 1.
Typhus fever, endemic.—Cases: Winston-Salem, 1; Atlanta, 2; Savannah, 8; Tampa, 5; Birmingham, 3; Mobile, 5; Little Rock, 2; New Orleans, 6; Galveston, 2; Houston, 2; San Antonio, 4.

Rates (annual basis) per 100,000 population, by geographic groups, for the 85 cities in the preceding table (estimated population, 1943, 33,935,700

	Diphtheria case rates	Encephalitis, infectious, case rates	Influenza		Measles case rates	Meningitis, meningococcus, case rates	Pneumonia death rates	Poliomyelitis case rates	Scarlet fever case rates	Smallpox case rates	Typhoid and paratyphoid fever case rates	Whooping cough case rates
			Case rates	Death rates								
New England	13.1	0.0	5.3	0.0	97	23.6	65.6	2.6	252	0.0	2.6	213
Middle Atlantic	6.5	0.5	4.2	3.2	19	12.0	51.4	8.8	123	0.0	1.9	104
East North Central	13.4	0.6	8.5	7.3	16	15.2	49.3	2.4	173	0.0	0.6	78
West North Central	24.1	0.0	6.0	8.0	18	10.1	84.5	0.0	147	0.0	0.0	52
South Atlantic	21.0	0.0	41.9	5.2	12	14.0	54.1	1.7	211	0.0	1.7	147
East South Central	11.8	0.0	5.9	29.5	142	11.8	141.6	0.0	71	0.0	0.0	18
West South Central	45.3	0.0	33.2	12.1	30	6.0	142.0	3.0	184	0.0	3.0	42
Mountain	0.0	0.0	56.0	7.9	64	15.9	63.5	0.0	230	0.0	7.9	111
Pacific	11.5	0.0	41.1	8.2	56	1.6	41.1	4.9	179	0.0	0.0	33
Total	13.7	0.3	14.8	6.3	30	12.3	60.7	4.5	162	0.0	1.4	92

PLAGUE INFECTION IN TACOMA, WASH.

Plague infection has been reported in a pool of 53 fleas from 2 rats, *R. norvegicus*, taken on November 25 at the water front in Tacoma, Wash.

TERRITORIES AND POSSESSIONS

Panama Canal Zone

Notifiable diseases—October 1944.—During the month of October 1944, certain notifiable diseases were reported in the Panama Canal Zone and terminal cities as follows:

Disease	Panama		Colon		Canal Zone		Outside the Zone and terminal cities		Total	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Chickenpox	11				11		2		24	
Diphtheria	5		1				3	1	9	1
Dysentery (amebic)							2		2	
Dysentery (bacillary)	1								1	
Leprosy							1		1	
Malaria [1]	9	1	6		56		50	1	121	2
Measles							1		1	
Meningitis, meningococcus	1								1	
Mumps	1				4				5	
Paratyphoid fever	2		1	1	3				6	1
Pneumonia		9		3	13	3		4	[2] 13	19
Tuberculosis		29		5	2	2		13	[2] 2	49
Typhoid fever							1		1	
Whooping cough					4				[2] 4	

[1] 29 recurrent cases.
[2] In the Canal Zone only.

FOREIGN REPORTS

CANADA

Provinces—Communicable diseases—Week ended November 25, 1944.—During the week ended November 25, 1944, cases of certain communicable diseases were reported by the Dominion Bureau of Statistics of Canada as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Chickenpox		25		263	380	44	69	56	92	929
Diphtheria	2	7	3	67	18	7	1			105
Dysentery (bacillary)				5					1	6
Encephalitis, infectious									1	1
German measles		1		16	11	2		3	5	38
Influenza		10			53	1			21	85
Measles				504	142	25	10	11	60	752
Meningitis, meningococcus	1	1	1	1	2		1			7
Mumps				245	189	10	2	36	56	538
Poliomyelitis			1	1	[1] 5	3	1	1	1	[1] 13
Scarlet fever		7	40	196	161	28	20	38	31	521
Tuberculosis (all forms)		3	8	180	56	5	15	11	30	308
Typhoid and paratyphoid fever		1		19	2			3		25
Undulant fever				15	3					18
Venereal diseases:										
Gonorrhea	2	36	13	48	121	29	39	22	44	354
Syphilis		9	5	146	89	18	12	12	21	312
Whooping cough		12		171	60	1	3	10	45	302

[1] Includes 3 cases, delayed reports.

MEXICO

Tampico—Brucellosis (Malta fever).—Under date of November 27, 1944, it is reported that a case of brucellosis has appeared in Tampico, Mexico. This is said to be the first case of this disease reported in Tampico and was carried by cow's milk.

REPORTS OF CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER RECEIVED DURING THE CURRENT WEEK

NOTE.—Except in cases of unusual incidence, only those places are included which had not previously reported any of the above-mentioned diseases, except yellow fever, during the current year. All reports of yellow fever are published currently.

A table showing the accumulated figures for these diseases for the year to date is published in the PUBLIC HEALTH REPORTS for the last Friday in each month.

(Few reports are available from the invaded countries of Europe and other nations in war zones.)

Plague

Algeria—Algiers.—For the period November 1–10, 1944, 6 cases of suspected plague were reported in Algiers, Algeria.

French West Africa—Dakar.—For the period November 21–27, 1944, 2 fatal cases of plague were reported in Dakar, French West Africa.

Union of South Africa.—For the 2 weeks ended November 25, 1944, 3 cases of plague were reported in the Union of South Africa, no specific location being given.

Smallpox

Rhodesia (Northern).—For the period October 22 to November 18, 1944, 136 cases of smallpox with 1 death were reported in Northern Rhodesia.

Sierra Leone.—For the period October 8–14, 1944, 11 cases of smallpox were reported in all of Sierra Leone. For the period September 10 to October 14, 1944, 11 cases with 1 death (including 4 imported cases) were reported in Freetown. For the period August 27 to September 2, 1944, 1 case of smallpox was reported in Bontha, Sierra Leone.

Typhus Fever

Algeria.—For the period November 1–10, 1944, 36 cases of typhus fever were reported in Algeria.

Hungary.—For the week ended November 18, 1944, 9 cases of typhus fever were reported in Hungary.

Rhodesia (Northern).—For the week ended November 18, 1944, 30 cases of typhus fever were reported in Northern Rhodesia.

Sierra Leone—Freetown.—For the week ended October 14, 1944, 3 cases of typhus fever were reported in Freetown, Sierra Leone.

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