ON NEW YEAR'S DAY of 1939, Robert L. Graves and I, on the way to Montreal, stopped in New Haven to see Dr. Cushing. It was to be the year of his 70th birthday celebration, and the year of his death. I had never met Dr. Cushing; he knew Graves because of a mutual interest in del Río-Hortega's laboratory in Spain. The ensuing conversation was very one-sided indeed until my colleague in desperation indicated that two years earlier, I had been Resident-Surgeon at the Johns Hopkins Hospital. Dr. Cushing turned to me at once and with his enormous personal charm said, "Ah, you and I have slept in the same bed." He was referring, of course, to that hard, wooden-slatted Halsted bed, a substantial honor bestowed upon Chief Residents in those days and certainly this bed was the precursor of the modern conservative treatment of sciatica. It was a delightful morning and near its end, Dr. Cushing turned to me and said, "Are you a member of the H. C. Society?" And I answered, confused but trying to be honest, "Sir, I have never heard of the H.C. Society." In personal extenuation, I must add the fact that I had lived and worked for eleven years on the opposite side of the neurosurgical railroad tracks, engulfed and surrounded by that tradition, much of which has never been fully described. I am confident, however, that you will agree that no one has ever attained this podium in past years from such a lowly beginning and I am very grateful for this honor.

The subject of this address has been announced as "Government, Medicine and the Common Weal" and I realize quite fully that even these bare words may arouse mixed emotions. I would say simply that the traditional doctor-patient relationship represents the final common end point of good medicine and this will always be true. This end point was sufficient unto itself in past decades and indeed past centuries. This is no longer true in the world of today. Economic, social and political changes that are inevitable have vastly altered the approach to this vital end point and the issues are matters of controversy. We must both understand these issues and participate in their solutions in a positive fashion. We must admit further the fact that other and new figures, highly responsible people, have entered upon the stage or the arena of good health, a stage once wholly occupied by the doctor and his patient. The debate is quite comparable to that now forming ranks about "public" versus "private" general education and the question being asked here is this, is higher education the fourth branch of government?

Nowhere in the history of neurological surgery can some of the issues and problems be documented better than through even a cursory review of the latter years of Cushing's life.

On October 8, 1934, he accepted membership on the Medical Advisory Committee to the President's Committee on the costs of Medical Care. This Committee supported the further use of public funds for preventive medicine and advocated Federal action to aid the building of community hospitals, perhaps the first support by citizens of the concept of the present-day Hill-Burton Bill. The Committee felt that the issue of national health insurance needed further study. Cushing said in closing a discussion of issues of social welfare at a dinner some time later of the National Institute of Social Sciences, "You will see how difficult these problems are and how they engender honest differences of opinion." Cushing had written to President Roosevelt and suggested a "super-
bureau of public health” but the President replied that the time was not ripe for such a drastic step, and Cushing returned to his own affairs.⁴

Some years later, it might be worth while to re-examine this particular scene and to restate the several issues that did concern Cushing to a considerable extent in the later years of his life. In essence these issues have broadened in their social significance and, at the same time, the moment for relevant decision is much closer at hand, being hastened as well by world-wide ideological differences of opinion, and by national issues such as racial equality, both of which carry resounding overtones of control of health. Let me attempt to state these issues in brief form.

1. The concept of comprehensive medical care for the entire population is a basic social right of every individual in the United States.

2. The objective of the total health services is to discharge that obligation.

3. The objective of medical education is to provide the training of the personnel necessary to meet such an obligation of service.

Dr. Willard C. Rappleye, President of The Josiah Macy, Jr., Foundation, has summarized these first three rather simple issues as follows:

“The American people are convinced that adequate health service should be made available to all members of our society and are determined that both the advancement of knowledge and the training of adequate numbers of competent health personnel for their benefit must be supported by the constructive use of their wealth through taxes as well as voluntary channels.”⁸

Here for the first time today we encounter the ugly word “taxes” and I believe that we can place this word in proper context by changing the title of this address from that of “Government, Medicine and the Common Weal” to “Federal Taxes, State and Local Taxes, Medicine, and the Public Weal.” I make this change purposely before we consider the following basic issues.

4. As of January 1, 1963, some 145 million persons, 79 per cent of the civilian population, were participating in some type of voluntary insurance in prepayment plans, or were themselves otherwise financially stable.

5. As a corollary, at least 23 per cent of the population cannot afford this type of protection and may be classified as indigent or medically indigent, and the economic protection of these groups of the population must be assured, and finally,

6. The voluntary hospital must assume a focal point not only in the care of the protected citizen, but in the care of the indigent and medically indigent citizen if the Federal Government’s obvious responsibility in this area is to be satisfactorily answered. The Permanent Administrative Committee of New York City in its report to the Mayor in relation to hospital problems presented another side of the complex matter:

“The Permanent Administrative Committee recognizes the necessity for some controlling body which is empowered to move vigorously and promptly to coordinate all services of the hospitals to meet the community’s needs efficiently and effectively. The time is past when each voluntary hospital can regard itself as a separate entity; each should be an integral part of a broad program to provide necessary medical service to the community at minimal necessary cost.”⁹

The focusing of attention upon the fiscal plight of the voluntary hospital is of import when studied in relation to the Hill-Burton program initiated in 1946 under the aegis of the Public Health Service. Since 1933, this program, a true marriage of community and Federal responsibilities, has provided 4,604 hospital and medical facilities across this country. These projects, costing a total of 4.2 billion dollars, have received Hill-Burton assistance, that is assistance of the Federal Government, amounting to nearly 1.3 billion dollars. This mixture of public and private initiative is a good example of a concept established in 1798 by representative government that where needs of national health are not being met elsewhere—because of the complexity of the problems, or the insistence of the need, or the magnitude of the resources required—the Federal Government has an obligation to help. The proper adjudication of this concept must always be a bilateral affair between medicine and government,