modern and usually competent. New medical knowledge has been produced largely in major medical college research and teaching hospital complexes, but the majority of health care has been delivered to our people through a distinctly separate system of community medical institutions.

Communication between medical education and research centers and community health care delivery centers began to deteriorate before and during World War II. It has become increasingly ineffective through the 1950s and 1960s.

Unquestionably, the federal system of research support has been productive in terms of knowledge, but it has served, through the tender trap of "soft money," to enhance greatly the difficulty in communication between the teaching and research centers and the community hospitals. Patterns of human behavior dictate that an individual infected with the virus of discovery—whether through financial or personal suasion—and whose job and family support are functions of continuing success in discovery, will lose interest at a rapid and predictable rate in the more mundane functional application of his discoveries, except as such application might further prove his theses. Understandably, as the Midas touch of research support produced more full-time faculty members who received their major support from investigation rather than teaching, less and less of their time became available to transmit and validate information from the medical college to the functional arm of the medical care system. These attitudes are both inevitable and defensible *within the system* that has produced them.

At the receiving end of this sclerotically deteriorating pipeline of communication between educational centers and care centers, other disruptive forces were at work. Most of the governmental support to our voluntary medical care system, as represented by our community hospital, is directed at bed needs. Provable demographic studies, leading to indicated increases in bed capacity, produce the highest priority of funding in hospital construction. Very little support has gone into the creation of diagnostic or treatment facilities unless they are immediately defensible by bed capacity. Almost no support has gone into nonpatient care and supportive facilities of an educational, evaluative, or analytic nature. Accrediting bodies stress in ponderous manner the necessity for smooth operation and recording of the administrative and business functions of a hospital and its medical staff, but pay almost no attention to the actual quality of the staff, or to any system of assuring the continued quality of the staff in terms of updating of knowledge and techniques.

The exceptions to this insistence on administrative and directive function have occurred in relation to two active forces: (1) incidental to approval of graduate programs (internship and residency), the American Medical Association's Council on Medical Education does insist on minimal standards of graduate education and on evidence of departmental educational activities in those departments operating approved programs; and (2) the American Academy of General Practice for some years has had an established minimum requirement in continuing education for its membership, which the academy itself recognizes as a minimal figure.

EMPHASIS ON BUSINESS FUNCTION

The predominantly lay boards and lay administrators of our voluntary hospital system frequently have contributed further emphasis upon bed capacity and direct bed support. It is a paradox that individual hospital board members, who are involved in corporate structures that place tremendous emphasis on continuing education in management techniques, psychology, and evaluation for their management personnel, neither insist upon, nor are oriented toward, the same emphasis on comparable continuing education activity in the medical staffs of the hospitals that are their community charge. The development of this orientation is again both understandable and defensible *within the system* that has produced it.

Businessmen tend to regard hopsitals as businesses and to stress their business function to the administrative group. Government and accrediting bodies understandably have been reluctant to impose continuing education requirements on the medical profession. Many examples around the country show that when the necessity for continuing education and its basic purposes in relation to medical practice are explained in a clear and knowledgeable manner, most board members and administrators are quick to recognize its import, but still may assign