Quo vadis medicina?

Grant V. Rodkey, M.D.

The author (ΑΩΑ, Harvard Medical School, 1942) is a clinical professor of surgery at Boston University and an associate clinical professor of surgery at Harvard University. He is director of general surgery Ward 4BS at the Boston Veterans Administration Medical Center and a senior surgeon at the Massachusetts General Hospital.

Physicians are currently enveloped in a revolutionary social challenge that involves the science of medicine; medical education; the financing, organization, and delivery of medical care; the traditional tenets of patient-doctor relationships; and even the ethics of medicine. In responding to this challenge, we need to reexamine the core values of our profession and to preserve those that are relevant to social need.

In considering these issues, I have been particularly influenced by the insight and writings of some of my fellow Massachusetts physicians, particularly J. Englebert Dunphy, M.D., "On Caring for the Patient with Cancer," 1976,[1] H. Thomas Ballantine, M.D., "The Crisis in Medical Ethics, Anno Domini 1979,"[2] and the Shattuck Lecture by H. Brownell Wheeler, M.D., "Healing and Heroism," 1990.[3]

Why are these three statements so outstanding? Because each of them deals in a very significant way with aspects of the most fundamental element in our profession — the relationship between patient and physician.

Medicine has its roots in prehistory, and a fascinating glimpse into its origins has been provided by a Massachusetts physician, Guido Majno of Worcester, in his book *The Healing Hand: Man and Wound in the Ancient World*.[4] Even in those ancient times, individuals possessing special skills in the care of the ill or the wounded were identified, so that nearly 5,000 years ago Imhotep was described as a physician as well as an architect in the Old Kingdom of Egypt during the reign of Pharaoh Zoser.

More directly, the traditions of Western Medicine are traced to Hippocrates, of the Island of Cos, who studied in the Temple of Aesculepius on Cos and also in Egypt about 2,400 years ago. Hippocrates laid the foundation for modern medicine by his emphasis on careful observation, methodical recording of observations, and clinical correlation of his results. He lifted medicine from superstition to a science, but he also gave it a soul. The "Oath" that he taught his students has survived to this day as a living code of conduct for physicians. In essence, he commanded good character, proficiency in the art, putting the patient's interest before one's own, confidentiality in the care of patients, generosity towards fellow physicians, and the faithful teaching of the art to one's successors. Universal attributes of medicine throughout the history of man have been the twin ingredients of a person in pain, distress, or illness, and a compassionate and more skilled individual providing comfort and assistance.

Remarkably, despite the immemorial suffering of man and the earnest efforts of physicians to comfort and help, most of the effective tools for treatment of disease and injury have become available within the past 150 years. With the discovery of ether anesthesia in 1846, a new epoch was born. The swift development of surgery, pathology, bacteriology, antisepsis-asepsis, and X ray closed out the nineteenth century. During our own century, the scientific basis for medicine has exploded at a logarithmic rate through physiology, biochemistry, endocrinology, immunology, antibiotics, transplantation, cell biology, chemo- and radiotherapy, diagnostic imaging, genetics, and every other related field. We are now forcing open the door of gene therapy, xenografting, and defining the human genome. A major impetus to the scientific advances in medicine has been the funding of research by private philanthropy through foundations and by the United States government through the National Institutes of Health. The science of medicine continues to expand, and we can be sure that before the younger members of our cohort retire, there will be an even greater explosion of knowledge than has occurred during the century just closing.

As our scientific skills have advanced, however, public confidence and trust in physicians seem to have declined. The extent of public reliance upon and expenditures for remedies outside the realm of scientific medicine is astonishing.[5] Political support for alternate systems of health care outside of the profession of medicine is always strong. As the training and certification of physicians becomes ever more thorough and scientifically based, demand increases for physician report cards, for their treatment outcomes analyses, for their malpractice claims data, and for more stringent penalties for fraud and abuse — all certainly manifestations of public distrust. What do these contradictions mean? What is their portent for the future of the profession of medicine?

Almost in parallel, the revolution in scientific medicine has been accompanied by great changes in the financing and administration of medical care. Otto von Bismarck, in 1883, secured passage by the German Reichstag of the Sickness Insurance Act. This act initiated the idea of state-controlled health insurance, which has spread in various forms throughout much of the world. In the United States the rise of health insurance dates from the Depression days of the 1930s. It received tremendous impetus during World War II and thereafter, when unions, business corporations, and government began to use the provision of health insurance as a tax-free fringe benefit to employee compensation. The enactment of Medicare and Medicaid in 1965 further increased the pool of individuals in this country covered by health insurance, both public and private.

In anticipation of greater utilization of medical care by insured individuals, the United States government, through enactment of the Hill-Burton Act of 1946 and subsequent amendments, stimulated the building of hospitals throughout the nation. The Health Professions Educational Assistance Act of 1963, with subsequent amendments, doubled the output of graduates of medical schools from 8,000 to 16,000 per year. Thus, from 1960 to 1994 physicians in the United States increased from 142 to 263 per 100,000 population with their numbers growing at a rate almost four times that of the general population.[6, p.16] That period also saw a rapid increase in specialization among medical graduates, with progressively longer and costlier training programs. Certain specialties appear to have reached a saturation point, with some 1995 graduates unable to find employment in their specialty. Yet, the medical schools and the graduate training programs grind on, and we have at least ten more years of current production quotas in the pipeline.

Thus, during the past half-century many factors have encouraged increased utilization of medical care: better science, more accessibility, more affordability (often with no out-of-pocket costs to the patient), increasing population, increasing longevity, and the ability to prolong tenuous life at both extremes (neonatal and senile). With the crescendo in services has come an explosion in the costs of medical care that was not moderated by the restraint imposed by the patient having to pay for the transaction — restraint that would have affected not only the patient but also the physician and institutional providers. This climate has encouraged emphasis on therapeutic medicine to the neglect of preventive medicine and has encouraged a reckless disregard of good health practices within a public whose members feel that whatever physiological damage they do to their bodies can be repaired by the magic of medicine — at no cost to the recipient! We live in an environment of epidemic violence, injury, and death, the antithesis of preventive health practices.

Of course, not all the ills of society are the fault of health care — or the lack of it. Many voices decry the decline in morality in our society. As members of that society, physicians inevitably share in the climate of the times. It should not be surprising to find that some physicians operate from motives of selfishness and greed, and that some engage in practices that are immoral or criminal. We know that only a small fraction of our colleagues behave in these ways; however, their ill repute goes far beyond their number.

Physicians' policing of their own ranks has been seriously hindered by the application of the antitrust laws to the learned professions since Supreme Court action in 1943, which classified the practice of medicine as a trade within the meaning of the Sherman Antitrust Act,[7] and its ruling in 1975 that the Virginia State Bar Association could not establish or enforce a minimum fee schedule for lawyers.[8] In the interest of protecting the public, the medical profession has tried diligently to regain the right to perform rigorous peer review without risk of antitrust prosecution. As yet, these attempts have not succeeded.

In the United States, the ferment of all these ingredients, catalyzed by the efforts of government and business to restrict the costs of medical care, has generated the rapidly evolving "managed care" variant of health insurance. The essential arrangement of all managed care is the interposition of a financial manager between patient and doctor, constricting payment for services and imposing restrictions upon the behavior of both parties, with necessary administrative fees (and often a profit margin) for the manager. If the physician's own earnings are to be diminished by expenditure outlays for the care of patients — a frequent arrangement — there is an incentive to undertreat, which may become near imperative. If the physician is at risk of losing employment unless he or she meets arbitrary goals of cost restriction, the twin pincers of physician glut and antitrust threat leave him or her defenseless in the advocacy for his or her patient. Two thoughtful analyses of the social dynamics of these changes are the Shattuck Lecture of 1983 by Alvin R. Tarlov,[9] and the book *The New Medical Marketplace*, with "Foreword" by Arnold S. Relman, M.D.[10]

So how did our great profession sink so low? Did physicians bring these conditions upon themselves? In part, they did; but, in the main, I think they did not. Before 1950, physicians generally were not highly paid. With the rise of third-party payors, however, fees could increase without an immediate direct negative feedback. Many physicians exploited that opportunity — some with unconscionable greed. This period was, of course, the one when organized physicians were proscribed by the federal government from reviewing and restraining fee gouging. Without doubt, the rapid increase in physicians' earnings attracted many candidates to the profession who were not motivated mainly by humanitarian impulses, further compounding the downhill spiral in idealism. These changes have generated both public envy and cynicism. The extremely high cost of medical education and postgraduate training, coupled with a decade's shorter span of lifetime earnings, do not excite pity among our critics.

The post-Flexnerian pattern of medical schools as separated, scientific institutes combined with rigorous and competitive premedical courses has resulted in the monastic segregation of medical students, residents, and physicians from much of the normal social interaction with other groups in society. Over time, this lack of close acquaintance breeds misunderstanding and distrust, and it tends to discourage physicians from taking leadership roles in their communities after their training has been completed. This separation is further compounded by the long days of work and irregular hours imposed on physicians by "demand scheduling;" that is, patient calls and needs.

Selfish impulses — perhaps combined with ignorance — may have hindered our making specialty choices on the basis of demography, or settling in the Wyoming hills or the Big Sky country of Montana, where physicians are scarce and social amenities may seem scarcer. These and other failures to respond to per-

ceived public need have earned us no affection.

Yet, we know as a matter of daily routine the devotion, skill, humane concern, and personal sacrifice that define the lives of the mass of our fellow physicians. After twenty-two years of service in the House of Delegates of the American Medical Association, I can attest to the near universality of that behavior among physicians in the United States. And after fifty-seven years of constant immersion in medical education, I think that most medical students pursue their strenuous studies still with the idealistic hope of being helpful to others.

So, how will we right the ship? First, we need a realistic acceptance of our present problems. There is no doubt that, as a profession, we have less public influence than formerly. It seems inevitable that physicians will be less secure in their employment and in their income for the foreseeable future, and that they will have less independence. They may be required to work even harder and for longer hours. Yet, each one of us has the opportunity to make a successful adaptation to the current pressures on our profession by controlling his or her own behavior. To take advantage of our opportunities for success, we should:

- Take a realistic inventory of our own assets.
- Recognize the power and potential of social interaction — politics — and be participants.
- Resolve to put patients' welfare ahead of our own — genuinely to love our neighbor and reflect concern and goodwill in our words and actions.
- Walk humbly — listen and respond to the questions and suggestions of others.
- Be open to change — in opportunity and responsibility.
- Strive constantly to increase our knowledge and skill as a lifetime commitment.

Our profession has suffered from the withdrawal of physicians from the political life of their professional organizations, their home communities, and the nation at large. A part of our challenge and opportunity is to educate our patients to the value of personal, preventive, health care and self-responsibility. We must assume leadership in health and behavior education in our home communities and associate ourselves actively in the political processes of government. To do this, surprisingly, is to conform with Principle VII of the Code of Ethics of the American Medical Association and the Massachusetts Medical Society: "A physician shall recognize a responsibility to participate in activities contributing to an improved community."[11]

And we shall magnify the effectiveness of our efforts if we work together in our state medical societies and the American Medical Association — as well as our specialty societies.

The long-term success of the profession of medicine is inextricably bound to the survival of humanity. Inescapable human need will demand our knowledge, skills, and compassion. Each of us — and even the most intransigent political detractors of the profession — will require the assistance included in the art and science of medicine. We are challenged through our present stresses to find more effective and more relevant pathways of public service.

Challenge, struggle, disappointment, and pain are not new, but they may become part of a renewal process. As a profession, we are forced to reexamine and refine our effectiveness, our systems for delivery of care, and even our own motivations. Medicine is a personalized bridge between science and humanity and must always be changing to accommodate knowledge and need.

Together, we look to the future with confidence grounded in the bedrock of human experience. Three and one-half centuries ago, in the era of Cromwellian England, when all social beliefs and institutions were challenged and disrupted, a church in Leicestershire was dedicated by this inscription:

> In ye year 1653, when all things sacred were throughout ye whole nation either demolished or profaned, Sir Robert Shirley, baronet, builded this church; whose singular praise it was to have one the best things in the worst times, and to have hoped them in the most calamitous.

Our great profession, sensitive and responsive to the vastness of human need, will regenerate as a beacon of hope for humanity.

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Send reprint requests to author at:
Department of Surgery (112)
Boston Veterans Affairs Medical Center
150 South Huntington Avenue
Boston, Massachusetts 02130