society in general and to the medical profession in particular, is out in the open and needs to be discussed by all of those involved in health care. This will be the most important issue facing our society in the next decade.

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Let's Discuss a National Health Service

R. BRUCE SLOANE, MD

LOOKING AT THE CONSTRAINTS and the influx of business and government into the medical profession I wonder whether the alternative of a national health service might not be debated more than it seems to be in the circles within which I mix.

For older persons, among whom I have the distinction or unhappiness of being, and in my role as a geriatrician and director of the Pacific Geriatric Education Center at USC, I am appalled at the complexities of health insurance. To get one's benefits requires a sharp mind, assiduity and many hours a day. The present expenditures by government through federal programs, whether they be Veterans Administration, Medicare or Medicaid, are very considerable. Canada enjoys a good national health service with which my physician friends seem to be well satisfied—certainly the consumers are. The last figure I had, which may well be much out of date, was that it consumed 8.5% of the gross national product.

In Britain, where the percentage of the GNP is considerably less than this, the physicians remain well satisfied—both specialists and the ever-growing number of family practitioners and/or GPs. There is an excellent training scheme over three years for family practitioners within practicing groups of such physicians and this training is much esteemed. Most patients are satisfied and I understood, again some years ago, that the national health service covered 93% of the country and a further 7% had private insurance. These two seem to work well in a complementary fashion despite the political outcries about "paybeds" in national health service teaching hospitals. There are undoubtedly long waitlists for elective surgery and the British scheme might be regarded as the lowest common denominator. Nevertheless, it works quite well and I have never had any success in recruiting young physicians away by the lure of Los Angeles (perhaps understandable when you think about Los Angeles).

Obviously a national health service would be like this country, pluralistic and different from other national health services. However, I believe that the total wealth of the country and the rights of its citizens demand something better than what we presently have.

Programs in health care require continuity and continuum. Nowhere is this more necessary than in the care of the aging. To do this there is a need to weld a number of disciplines and services together which is very difficult in our present inchoate system. In both Canada and Britain, which I am familiar with, considerable steps have been made in coordination which did not exist prior to a national service.

On the debit side is clearly the threat of unemployment of physicians and many chasing the few desirable jobs and locations. However, with the ratio of physicians to population in California, for example, I do not believe that we are escaping that in this country and look toward the next two decades as becoming much worse in this respect. Thus there will be direction by scarcity of jobs or the demands of hospital corporations. Perhaps a national health service would be a better solution.

In addition, I believe that vital humanistic values will be restored to medicine when we are not competing so vigorously against each other.

In conclusion, and thinking at the end of what I was trying to say in the beginning, I am perhaps urging more open debate of what often seems to be a most unwelcomed topic. If this occurs I believe we will move more readily into a resolution of our present constraints.

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Refer to: Sloane RB: Let's discuss a national health service, *In* The aim of American medicine within the constraints of today's society—A forum. West J Med 1986 Sep; 145:401

The Glass Is Half Full

GEORGE A. PORTER, MD

"PHYSICIAN HEAL THYSELF." Could this be the antidote for the changes facing our profession? As one reads the eight essays in the August issue reflecting on the theme "The Aims of American Medicine Within the Constraints of Today's Society," it can be viewed as a struggle for survival or a challenge to recapture lost esteem. I choose to view the glass as half full rather than half empty and suggest that the profession must establish its priorities based upon patient advocacy. Obviously, this imperative must be reconciled with the financial, social and legal restrictions that society imposes; however, alternatives do include changing society's attitude.

Common sense combined with empathy toward our patients will point us in the right direction. Putting our patients' welfare ahead of our own self-serving interests will help to recapture the lost trust and respect we have suffered during the rapid expansion of medical technology. This is not to say that we abandon progress, only that it be advanced with liberal amounts of humanism. We can no longer permit vested interests to dictate health policy anymore than we can allow the practice of corporate medicine.

We are facing major contradictions which demand acceptable compromises. How does a physician remain a patient advocate while acting as a "gatekeeper" to restrict entry to health care? We are exhorted to retain a quality service but reduce the cost of the service. When does the relief of pain and suffering become postponement of death to a medically sophisticated population with high expectations for success,

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no matter how great the risk? How can we advance medical service and yet provide a cheaper product?

For certain of these issues, a national forum convened by the leadership of medicine may be the most expeditious starting point.

Healing First, Dollars Second

MERLE S. SCHERR, MD

THE ONLY STATEMENT in the forum published in the August issue that was really interesting to me was that entitled "The Credo of An Honored Profession" by Lonnie R. Bristow.[1]

The basic theme of Dr Bristow's article is sound: "healing first, dollars second." Unfortunately not all physicians would agree with this in actual practice and belief. It is also not really "medicine against the world" although one of our biggest problems is that far too many physicians appear today to be just as guilty as the corporate world in putting dollars before healing. The house of medicine is far from unified on this subject. Were we truly and solidly behind the philosophy of "healing first, dollars second," it would be much easier to defend our honored profession and close ranks against those who would dishonor it.

It seems to me that Dr Bristow's article should be distributed both for internal consumption (within the profession) and outside consumption (by the corporate, business, governmental and regulatory segments of society). The article has substantial political value, although of course there is nothing particularly new in the philosophy presented. Some of the examples given in the article—such as corporate acquisition of medical schools and a Southern California HMO advertising that its hospitals will kick back a portion of profits to those doctors admitting patients with medical diagnoses that result in big profits to the hospital under the new Medicare system—appear to be illegal under the Medicare Quality Assurance Act of 1986 which is introduced by Senator Heinz (R-Pa) and Representative Stark (D-Calif).

We must agree with the message presented by Dr Bristow but more is required in implementing his recommendations.

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Refer to: Scherr MS: Healing first, dollars second, *In* The aim of American medicine within the constraints of today's society—A forum. West J Med 1986 Sep; 145:402

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