Forum

The Aim of American Medicine Within the Constraints of Today's Society

Beginning in the August 1986 issue the editors of *The Western Journal of Medicine* began a forum for dialogue and discussion of the aim and purpose of medicine within the constraints now being placed on health care. Readers and others are invited to submit their views constructively and succinctly. As many as space permits will be published in future issues of the journal. At an appropriate time all the material will be collated and, if possible, the distillate will be prepared as a statement on "The Aim of American Medicine Within the Constraints of Today's Society."

MSMW

Be a Pilot, Not a Pirate

LAURENS P. WHITE, MD

IN *The Pirates of Penzance* Gilbert and Sullivan create some tension and a lot of humor by having the Nurserymaid, who is hard of hearing, make the mistake of apprenticing the young lad to a Pirate, instead of a Pilot. It is my aim, within the constraints of a short piece, to try to convince you to be a Pilot.

Professor David Stafford-Clark has suggested that the role of physicians in dealing with dying patients should be that of ships' pilots, guiding the patient through narrows or shallows, or in or out of dock. He emphasizes that the patient was the captain, who was responsible for the voyage, but who needed help at the beginning and the end, and occasionally in between. The pilot has his own journey, and can't go on the trips of others, but his job is to help others in their ships when they need help.

Our aim, as physicians, is and has been to practice the best medicine we can. For the past 40 years this has been, increasingly, good technical medicine, and we have, increasingly, ignored the human condition, instructed and accustomed as we are to treating the disease, not the patient. We bought the illusion that all we needed to do was to treat the lab value, the x-ray, the disease—and the human condition would take care of itself. Through this period our departments of pediatrics, medicine and surgery were taken over by biochemists and biophysicists who valued knowledge of enzymes highly, knowledge of feelings and needs little or not at all. Students got the message that the road to their salvation was through intermediary metabolism, which they studied and learned, and not through learning to care for and deal with a sick person, which they neglected. Marvelous scientific advances occurred via this emphasis. (A previous generation of professors, who were just as interested in chemistry and research, carried their humanity and love of people into their bedside teaching.)

Sam Standard, a wise old surgeon, quoted his patient Karen Blixen as telling him "When I'm with you I feel I am in loving arms." (She had no particular pleasure in his knowledge of the Embden-Meyerhof pathway.) We, as physicians, need to communicate our ability to love and understand every bit as much as to sell our technical skills. Patients expect more from physicians than they do from other health care workers, and to us they give up more of their independence. Most patients are aware of the severe limitations of the knowledge of a chiropractor, and come to such a person with limited expectations. Expecting little, they give up little independence to such a person. They count more on us. Curiously, what is expected is not only the technical things but more of our concern, of caring, of being able and objective in helping them through their difficulties, of being a pilot on their journey. They want a person who can take charge, when that is needed, and who can then let go. Physicians/pilots aren't needed for the entire trip.

Modern society is more and more critical of physicians, of our incomes and our behavior. We physicians are in pain because of a bizarre dilemma: as we know more and more and can perform greater and more complicated scientific wonders, we are coming under increasing criticism and are liked and respected less all the time. At least part of our failure must be our failure to reassure or convince people that we care for them. In part our problem stems from not having learned that behavior patterns that work well in acute, time-limited illness are maladaptive for treating patients with chronic illness. Part of our diminishing status may come from the helplessness and dependence that illness forces upon people, and from the resentment by sick persons toward those upon whom they have become dependent. The increasing hostility that we see in our patients may be, at least in part, a reaction to this feeling of depression and helplessness; a change in our concept of our role as physicians may diminish the anger and hostility we face from patients. In this sense we need to be willing to take charge during acute problems, give support and reasonable options for patient choice in the care of long-term illness and be concerned about maximum freedom the rest of the time.

As pilots we need all our technical skills to help the vessel

Dr White is Clinical Professor of Medicine, University of California, San Francisco, and Chairman of the Council of the California Medical Association.

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through the trouble spots. As human beings we should try to limit these technical aspects of our job, and increase our human ability to deal with both the captain and with the crew. We need to delight in and honor our role as pilots, who leave the ship as it reaches the open sea. We can be called back if we are needed, but we have our own journey to take and we want it to be in freedom.

Medicine in the Future

JOHN L. KELTNER, MD

As WE LOOK to the future of medicine, it might serve us well to review the past. Certainly it is well known that history tends to repeat itself and the excellent book *The Social Transformation of American Medicine*[1] by Paul Starr emphasized this message. Many efforts have been made to develop governmental controlled socialized medicine. However, this has failed for many reasons which include the tremendous cost associated with government-run bureaucracies and the public's desire for independent free choice in a health-care system. Government's obligation to provide health care for the indigent and the poor resulted in the Medicare and Medicaid legislation of the 1960s. However, the tremendous cost associated with Medicare and Medicaid prevented further socialized programs from being developed.

The escalating costs of health care was one reason corporate America entered the health care system and, as Paul Starr relates in the last chapter of his book, we are presently in the era of the corporate takeover of American medicine. This has created several problems for modern medicine. Corporate America thrives on competition and, now that advertising is permissible, advertising and "marketing" have become the latest innovations to take place in modern medicine. However, the problem of ethics with advertising and marketing is producing tremendous difficulties for physicians today. We are defining new standards for the future, whether we like it or not, regarding what are ethical and unethical advertising. It has yet to be defined what these two standards really are, but clearly they will need to be spelled out if we are to continue to hold public confidence in our profession. Ethical advertising would be, one hopes, information transfer with public service in mind while keeping the promotion of self-serving needs of the individual or the institution to a minimum. Unethical advertising would be the use of the media to promote untrue or overstated claims about abilities or treatment options provided by an individual or institution. Clearly new standards in the fields of advertising and marketing for medicine will need to be defined. All medical advertising does not need to be bad, and if the public benefits by being better informed about their health and the potential services available to them, then all of society will be benefitted.

Cost containment is certainly an essential ingredient for medicine in the future. As pointed out by Beverly Myers in her article "Corporate Profits or Public Good"[2] in the August issue, the poor may suffer as corporate America takes over medicine. I would contend that there are three major problem areas that will suffer if corporate America takes over medicine without careful planning for them. The first is the care of indigent patients, who are already being squeezed out of the marketplace as private hospitals attempt to sign up HMO groups, PPO groups or other corporate centers. One way to take care of indigent patients would be to have each county foot the cost and care of indigent patients among all its hospitals and physicians on a proportionate basis. Thus, if there are ten hospitals in a community, each hospital would be responsible for providing 10% of the care for indigent patients. This would prevent the old "county hospital" or "city hospital" problems and would continue to provide quality care at hospitals that are maintained by corporate medicine but with high quality of care standards. The second problem area is research into the treatment and prevention of a variety of diseases—work which may suffer seriously as government bows out from subsidizing medical research. James C. Abegglen and George Stalk, Jr, in their book *Kaisha, The Japanese Corporation,* relate that in Japan the manufacturing industry finances almost all research and development that it performs and that the Japanese government finances limited research. With the corporate take-over of American medicine, it is also corporate America's obligation to be much more involved in sponsoring research into the treatment and prevention of devastating illness. Because corporations will benefit from new science which develops drugs, medical devices and surgically related material, they should fund a much larger portion of medical research dollars.[3] And third is the problem of who will provide the funds for teaching future generations of doctors if corporate America takes over without some type of governmental assistance for education. While we appear to have a doctor glut at present, without careful planning and if there is continued loss of funds for the training of future health practitioners we could be in serious difficulties in the future. Thus, the care of the indigent, research into the prevention and treatment of disease and the teaching of our future health-care practitioners must be carefully factored into the future corporate takeover of American medicine. Undoubtedly the government will continue to have to play a major role in financing these three major health care functions in the future.

As pointed out in James O. Mason's article "Medicine's Aims, Society's Constraints,"[4] prevention of disease through better education of the public should be the major thrust of future medicine. Clearly we have a generation of "video junkies" who gain many of their views and attitudes through television, whether we like it or not. If nearly 65% of the years of potential loss of life before age 65 is preventable, we need to have a constant barrage of TV informational items every Saturday morning, for example, informing our young minds about the potential risks of drugs, smoking and alcohol, and the potential benefits of proper diet, exercise and rest. Joseph A. Califano, Jr, in *America's Health Care Revolution,* calls smoking "slow motion suicide," a menace which he states has taken more American lives than all our wars and all our auto accidents combined, and, in addition, that "alcohol is a grim reaper involved in five of the ten leading causes of untimely death in America."[5] Thus, it is hoped that if we can educate a new generation about the hazards of

Dr Keltner is Chairman, Department of Ophthalmology, University of California, Davis, School of Medicine.

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