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Presidential Address

Dilemma of the 1970's

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THERE have always been differences of opinion between the laity and the medical profession relating to the delivery of health services. The next few years will very likely engender a more overt philosophical conflict that challenges some of the basic principles of a democratic form of government on the one hand and the traditional prerogatives of the medical profession on the other. The issues should be comprehended and the implications of the various solutions should be anticipated and evaluated with deliberation if the attenuation of sound social and professional principles is to be avoided.

The growth of organized medicine in this country as represented by several large national organizations such as the American Medical Association and the American College of Surgeons, along with many regional professional groups, specialty societies, and certifying boards has occurred with as little coordinated planning as has the growth of the large municipalities in this country. The cities, now unable to cope with almost insurmountable problems of housing, education, employment, welfare, transportation, communication, pollution, and administration, are foundering at a time when the lack of synergistic effort and foresight prevents an effective response to the needs and demands of society.

The health professions have had a comfortable evolution in this country, unencumbered by rigid non-professional controls and direction. Medicine, in this democratic society, has had a limitless amount of freedom to chart its own course of development and it has done so with the blessing of the public, primarily because individual physicians, with very few exceptions, have been responsive to the needs of their patients, and the distribution of medical services has met the needs of the overwhelming majority of the public.

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The various segments of the medical profession have traditionally organized themselves to attain professional identity and to promote the advancement of knowledge and skill in their respective professional fields. They have brought about almost incredible advances in knowledge and skills which have permitted the development of scientific medical practice that could hardly have been imagined 50 years ago. In the process, however, each segment of medicine has attained a degree of autonomy that encourages a disinterest, at times amounting to disdain, for what the other segments are doing, and especially for the total health care system.

Individual physicians have made enormous efforts and hospitals have provided significant portions of their resources to meet the medical care requirements of their communities. It has become apparent, however, in the recent past that the profession's interest and capability to deliver curative services exceed its ability to prevent illness, trauma, and disability. Now the medical profession is being challenged by society and its governmental representatives to redefine its goals and to provide the human and material resources required to exercise as much influence upon the maintenance of health as it has upon remedial care, and to do so for all segments of society.

In spite of the devotion of practically all individual physicians to providing excellent patient care, the medical profession as an organized segment of society has displayed a poor corporate conscience for the total needs of the public. Its own professional fragmentation, resulting in a lack of organization and clearly enunciated societal goals, has created a vulnerability which can threaten the freedom of the profession.

The socialistic programs adopted by the federal government since the 1930's in this country are natural phenomena and represent in a broad way the failure of the private sectors of society to respond adequately to universal needs.

In the process of responding to the needs of society, as expressed by its governmental representatives, the medical profession has considerable apprehension about socialistic programs for the delivery of medical care. Most, if not all such programs, are concerned with quantifiable factors that can be measured, categorized, and analyzed for statistical information. The subject of quality of professional services, difficult as it is to define, is ignored conspicuously in such programs. Mediocrity becomes an acceptable standard. One of the great incentives of the individual physician and especially the surgeon is the pride and satisfaction derived from the quality of service he provides. Any program that does not recognize this important factor in the daily life of a physician will elicit not only an overt hostility to the acceptance of the program but will, if arbitrarily imposed upon the profession, deter highly motivated young men and women from embracing medicine as a career and ultimately disenchant the consumers.

If an effort is made to analyze the current position of the medical profession, several observations can be made that require not only medicine's attention but the deliberate thought of all concerned with future methods of delivering health services.

In a sense, the medical profession is now engaged in a conflict with society. The profession will continue to make a maximum effort to preserve its independence and capacity for self-determination. Society will make progressively greater demands for more prevention of disease, standardization of methods for delivering care, better distribution of care for all social and economic groups, and increased opportunity to participate in designing the structure of medicine. Although the dilemma at times may appear insoluble, the objectives of both society and the profession can be attained with reasonable assurance as long as the principles of a democratic society are preserved and the responsibility for the solution of the various issues is clearly defined.

The first alleged defect of the current health care system is the lack of availability of medical care to specific segments of the populace; namely, residents of the inner cities and rural areas. Criticism of the care provided in these areas has been generated by observations of the incidence of malnutrition, neonatal mortality, lack of immunizations, and the advanced stages of many diseases unrecognized at a time when more effective medical care might have been provided. Some of the proposals designed to overcome these defects are conceptualized as programs of health maintenance.

For two reasons, the role that the medical profession can play in providing preventive services in this arena is relatively small. Most of these problems are intrinsic to the environment in which medically indigent people reside and they will be resolved not by any dramatic change in the way medicine is practiced but by vastly improved opportunities for education, housing, and employment. Physicians as citizens can participate effectively, as can any socially motivated individual, in bringing about the social, environmental, and economic changes required to improve the health status of medically deprived citizens, but organized medicine can accomplish little that any other well-defined segment of society cannot influence equally well.

A great deal is being said today about the need to provide comprehensive care to many people who have not in the past enjoyed the benefits of a continuing surveillance of their health needs by a physician. This type of professional attention is not desired by all people and indeed is unacceptable to many in the inner cities. An extended period of education is necessary, and many of the deficits of daily life must be corrected before this segment of the populace will accept any medical services that are not required to correct an acute illness or injury.

The second apparent defect of the current system is the lack of availability of primary or family physicians. The most important service such a physician can render to his patients, other than providing continuing and comprehensive care to those who wish it, is to provide an effective entrance to the health care system irrespective of what the patient's complaints are. In most instances, he should be able to manage the patient's illness, but when specialized care is necessary or desirable, he represents access to the appropriate facilities and personnel. The precipitous decline in numbers of general practitioners and the progressive diversion of internists to subspecialties has elicited a predictable response from the public. Many patients are directly selecting the specialist considered appropriate for their immediate problem. Many specialists, medical and surgical, continue to serve some of their patients as a primary physician after they have provided some special service. Progressively more people are relying upon physicians representing many different specialties but working as a group. In the large cities more and more patients are seeking care for acute problems at the emergency wards of large general hospitals, in part because of the unavailability of primary physicians, but also to a recognizable extent, because of an increasing appreciation by people from all social levels of the capability of a general hospital to provide whatever professional and material resources are required to contend with an acute illness. Immediate attention should be directed to the problem of organizing emergency services on a community wide basis and to improve the efficency with which they are conducted. By whatever manner or means this competitive situation is resolved in the future, it should be solely with the objective of providing patients with excellent, prompt, and efficient care.

If personnel deficits in the medical profession exist today, and there is ample reason for accepting this premise, it is in the area of general internists, general pediatricians, and family physicians. The un-

qualified statement arising from many sources concerning this country's need for 50,000 more physicians has very little meaning. If additional physicians are distributed proportionately over the professional spectrum of specialties which now exist, the public's need will not be met. Unless the medical profession itself obtains and studies badly needed facts about the quality, quantity, and distribution of service now provided and unless some mechanism is developed within the profession to exercise some form of incentive, guidance, or even control, it will be a long time before a reasonable balance and distribution of professional capability result from the permissive but competitive environment within which physicians function.

Whether additional general internists and pediatricians on the one hand, or family physicians on the other, provide the answer to the public's need for more primary physicians is a matter of debate with strong opinions being expressed by the proponents of each. Whichever group is accepted by the public, the mechanism for increasing the number of primary physicians lies within the medical schools and the affiliated teaching hospitals. Unless the appropriate image of the primary physician is created in the teaching environment, there will be little incentive for medical students or residents to pursue such a career. Students must have the opportunity to learn as a participant what the primary physician does and to understand his problems and rewards. It is also apparent that the academic status of the teacher of primary health care no longer be that of a second class citizen if recruitment of students and residents into this field is to occur. Without inducements the spell of specialty practice with which the student is surrounded will continue to be too enticing.

The resolution of the problems of maldistribution of health care and the lack of primary physicians cannot be resolved unilaterally but will require the combined efforts of the medical profession and the federal government.

In approaching these problems, the federal government, mainly through the legislative branch, relies heavily upon advice and demands expressed by consumer groups. Its concern is almost invariably oriented toward service programs which are characteristically regarded as the total answer to the demands of the public. The government, of necessity, takes into consideration costs involved in changing or creating service programs. It is not uncommon, however, for the projected costs to be grossly underestimated and, when the realities of life are revealed, someone other than the legislators' own ineptitude receives the blame. The medical profession is regularly the target. The overwhelming defect, however, of projected programs for the delivery of health care is the negligible consideration given to the professional, paramedical, and material resources required to implement and successfully conduct such service programs. Logically anyone contemplating a new or expanded medical service program should first determine the actual need for it, and then identify the professional and material resources required to attain the objectives of the proposed program. If resources are not available, efforts should obviously be made to provide them before the actual delivery of service is initiated if disenchantment and frustration are to be avoided. But the need for elected representatives of the people to respond to the vocal demands of segments of the public is so obvious that it is naive to expect that any significant change in legislative methodology will occur in the foreseeable future unless vigorous efforts are made by the medical profession to participate in the planning of national health programs.

All of the difficulties in finding effective solutions to the health care problems of this country cannot be ascribed to the federal government. The medical profession and many of the allied health professions must

assume a share of the blame. In this political system, the federal government should be responding to proposals of the health professions to resolve the problems of medical care, rather than the professions permitting themselves to be placed in a position of responding in a defensive fashion to overtures by the federal government. The question of how and why the medical profession repeatedly finds itself in this position deserves some comment if any constructive change is to occur in the future.

The remarkable degree of freedom which the medical profession has enjoyed in its evolution has been previously noted. Individual and organizational freedom in the profession can be tolerated only as long as the needs of the whole society are met. Since World War II, permissiveness has been an increasingly apparent attribute of this society. It is seen in all walks of life; the family, schools, church, industry, and the professions. Education has advanced in this country to the point where one might expect individuals and identifiable segments of the society to behave with sufficient self discipline and concern for others that the total needs of the people would be satisfied. Such is not the case, and it is also obvious within the medical profession where the separate specialties have considerable difficulty in projecting their sights beyond their self determined objectives. At every level of professional activity there is a lack of cohesiveness and a reluctance to appreciate even the need for combined efforts to attain objectives that are meaningful for departments, schools, universities, teaching hospitals, specialty and national organizations, and ultimately the public.

This lack of acceptance of a communal objective can be illustrated by the organization of departments of surgery in medical schools and their affiliated hospitals. The growth of surgical specialties has been so intense in the past several decades, and their desire for freedom and identity so profound, that as many as eleven separate and autonomous divisions or departments have been created in some medical schools. The objectives of a medical school are to teach undergraduate medical students, and to create and disseminate knowledge. A correlative objective, since medical schools do not generally have the formal responsibility for graduate clinical education, is, for example, the development of competent resident surgeons. The basic substrate of all this professional activity is the student and the educational process. Surgery in its broadest denotation is a well-defined professional discipline, whether the operating surgeon is dealing with a brain tumor, a thyroid adenoma, cardiac valvular disease, carcinoma of the larynx, appendicitis, scoliosis, ureteral calculi, or a fractured tibia. The institutional or corporate objective of the combined segments of the surgical faculty or staff is to provide a thorough education in the principles of surgery. A secondary objective is education in the surgical specialty a young man selects for a career. Without a cohesive effort, which can be attained by any number of effective administrative organizations, the breadth of surgery cannot be brought to the student, and many of the basic principles of surgery best illustrated in the separate areas of surgery can never be impressed upon a young man or woman. There is little excuse for a department of surgery to be so loosely organized that the separate specialties fail to communicate with each other effectively, all to the detriment of young men and women seeking an education and professional competence first as a physician, second as a surgeon, and third as a specialist.

At the national level, the fragmentation of all medicine, including surgery, is so extensive that it would appear almost impossible to unify the efforts and activities of its many parts into an entity that would be responsive to the total needs of the nation. It is possible that such an amalgam-

ation of effort will occur only when nonprofessional forces have imposed upon the profession an arbitrary federal system for delivering health care. The events that have taken place in the Province of Quebec within the past year should be viewed as a precursor of more extensive but similar episodes in the future unless medicine develops an organization which has society's best interests in mind and which can act voluntarily and effectively for the entire health care system.

Since this is unlikely in a politically turbulent profession within a permissive society, surgery must put its own house in order even if it is a unilateral action. Surgery represents a large and distinctive fraction of the total medical profession, and by assuming leadership in identifying its problems, activities, intraprofessional conflicts, and relationships with society it cannot help but be of assistance in the solution of the nation's problems in the health care field. Surgery should always be prepared and welcome the opportunity to join with the whole medical profession or any part of it in combined efforts to resolve national issues, if the remotest opportunity exists for success.

The American Surgical Association and the American College of Surgeons have joined in a study of the utmost importance. The broad goals of the study are to evaluate the potential for improvement in the organization and delivery of surgical services to the people of the United States so as to assure that surgical needs will be met in an efficient and effective manner whereby all individuals will have these services available and accessible, and whereby the surgical profession will be able to maintain a high level of quality in the delivery of those services. This study represents a new era in professionalism in that a large segment of the medical profession has acquired a social conscience, is mature and secure enough to subject itself to a probing self-analysis, is committed to examining the results of the study in the best interests of the public, and is sufficiently responsible to make rational changes for improvement. It would be naive to think that this study will not disclose defects in our existing system which relate to the education of surgeons, the staffing of teaching hospitals, financing of surgical care, and relationships with the federal government and other parts of the medical profession. The purpose of the study, however, is to expose frankly and factually our problems to ourselves and to overcome them in a deliberate and rational fashion. The goal to which our attention must be directed constantly is excellence in all professional efforts. Quality in the education of surgeons and the delivery of surgical services is difficult to define and yet every mature experienced surgeon understands it. Quality in surgery means first of all the image created by a surgeon in the care he provides his patients; constant and meticulous attention to the patient's total needs, an awareness of the psychologic trauma experienced by surgical patients, decisions made with the patient's best interests in mind, and the avoidance of any unnecessary surgical trauma. It also means that the surgeon has an appreciation of his own limitations, a willingness to seek advice and assistance, a continuing effort to expand his knowledge of abnormal human biology, a willingness to discuss and learn from his own errors in judgment, and a pervasive desire to provide for those surgeons who will follow the maximum incentives and opportunities for professional growth.

Change will unquestionably occur. The surgical profession will not only be required to adapt to changing social needs, but it must be in a position to initiate desirable change. One adaptation, however, which, I trust, will be rejected unequivocally and forever is any compromise with quality.