Responsibility of Organized Medicine in Medical Care*

KENDALL EMERSON, M.D., F.A.P.H.A.

Managing Director, National Tuberculosis Association, New York, N. Y.

THE responsibility of organized medicine for medical care seventy-five years ago was approximated one hundred per cent. Since then a number of factors have appeared which leave the definition of this responsibility less clear. Such factors include the public health service, the trained nursing service, medical-social workers, organized industrial medicine, government care of the chronically ill, and a significant change in a health-minded public's attitude toward its rights in the matter of adequate medical care.

Meanwhile organized medicine has plodded along, jealously guarding some of its traditional practices, making concessions in others, usually trailing rather than leading in the changes that have occurred in the evolution of medical care. Mark carefully that this does not apply to individual physicians who have been fundamentally responsible for most of the sound progress in the above fields related to medical practice. We need only mention such names as Stephen Smith, Welsh, Delafield, Biggs, Gorgas, and the like, to convince ourselves that a full sense of the physician's responsibility for medical care of all the people has found a lively abiding place in such minds as theirs.

The psychologists long since discovered that an organization is something different from the sum of the individuals of which it is composed. There is a mob psychology which is not epitomized in any single member of the crowd. Organize a professional group and you produce an effect on its members alien to each as an individual but which becomes the common property of the group and may warp its thinking. The worst result of such organization is the tendency to stress "rights" rather than "responsibilities." This has been a notable shortcoming in many of the pronouncements of organized medicine as expressed through American Medical Association spokesmen.

There is nothing about rights in the title of this paper. Any discussion of them would lead us too far afield. I shall take it for granted that we all agree that in 1850 medical care of the people was both a *responsibility* and a *right* of the medical profession. There was nobody then to challenge this status. Today, however, laws have stepped in to define rather closely the doctor's rights; and new social forces, new medical discoveries, new and accepted government controls have appeared to assume at least part of the responsibility that once was exclusively his.

Under totalitarian rule full respon-

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sibility for medical care has been assumed by government. Organized medicine as well as the public health service is centrally directed by a council, trained or otherwise, from whose orders there is no appeal. On the other hand, in our democracy responsibility for medical care may have been allowed to go a bit too much at loose ends. This was perhaps unavoidable under a system where, until recently at least, the principle has prevailed that the less government we have the better governed we shall be.

Somewhere between these two concepts of responsibility for medical care lies a better way. Search for that way is engaging the attention of many able minds in our country. At the present time organized medicine is beginning to find it is profitable to think less of its *rights,* and more important to assume leadership in taking upon itself its *responsibilities* for medical care in the light of our modern social structure.

To do this, organized medicine is showing a tendency to go to school and study with a somewhat more liberal vision its place in the community of today. It looks with less heat and with more sympathy and understanding on the other official and social organizations lately come into the field which have the power to be medicine's staunch allies, but which at times and with some reason have proved themselves unkindly critics. In short, organized medicine is realizing that although it is an indispensable part of modern society, nevertheless social evolution has struck a pace hitherto unknown, a pace quite foreign to the dignified and deliberate traditions of medical practice. Today the doctor must be a citizen first and must understand the demands of citizenship as well as those of his profession. Organized medicine's first responsibility in medical care, then, is to insist that its members gain a clearer understanding of the changes in social structure which this century has produced.

Of the several social forces which have arisen in recent years to nudge organized medicine out of its accepted traditions of practice, effective popular health education is in some ways the most insistent of all. While organized medicine has remained largely concerned with attempts to cure the sick, the public has been taught the concept of health as not only an attainable but a maintainable commodity. The people are demanding more of their private physicians than the latter are either trained or particularly eager to dispense. Organized medicine has a very different public to handle from that which it had even a generation ago. Writers of popular books on medical subjects have descended like locusts on the land. Some of these are good; some are harmful. The busy doctor has no time to read them. His patients have, and are often critical and even suspicious if he is not as familiar with them as he is with the writings of Osler.

A second responsibility of organized medicine in medical care has to do with its own economics. The practising physician, both in general and in specialized practice, is a highly essential factor in human welfare. He must survive and serve, no matter how far preventive medicine may be perfected in the future. Accidents will happen, babies will be born, men will die, as they always have. On the other hand, the costs to the practitioner of maintaining himself, his family, and his work are increasing yearly, almost daily. The amount of preparation required grows; expensive mechanical equipment becomes indispensable in both diagnosis and treatment. With the improvement in preventive measures and the conquest of one epidemic disease after another, the actual care of the sick is relatively reduced. The discovery of new diseases to treat does not keep

pace with this reduction. Certain areas are definitely over-supplied with practitioners; other regions are undermanned. Survival is becoming a matter of distribution.

In facing this difficulty physicians themselves have tried many experiments along the general line of group practice. At these reasonable efforts, organized medicine has shown a tendency to look askance. The most outstanding instance is the recent experience in Washington, D. C., where organized medicine came very near falling into the toils of the Sherman Anti-trust Law. It escaped, but the principle seems to have been established that the local medical society, a fraction of the A.M.A. cannot prohibit other societies from practice when they are "organized legally and with rules relating to membership or behavior of members that are not found to be illegal." This principle holds even though such societies do not meet the approval of the local medical society.*

While its members are being driven for economic reasons to accept salaried positions, often in state pay, organized medicine still clings to its age-old belief in what it refers to as the freedom of the medical practitioner.

Three questions arise: Is this freedom as actual as it appears? Is it worth the uncertainties and financial difficulties faced by organized medicine? Is it worth the constant and irritating charge, supported by far too sound argument for complete refutation, that the people of this country are receiving inadequate medical care under the existing system?

The answer to the first is that, of course, the freedom of the medical practitioner is not what he thinks. In the first place he is already hemmed in by laws and restrictions limiting his practice in many ways. Second, he must rely on publicly supported hospitals, outside his control, for the care of many of his patients. Third, he is sadly limited in what he can now do by way of treatment because of the restricted financial condition of his patients themselves. The scientific practice of medicine is one thing; the possibility of its actual application quite another.

The answers to the other two questions, that of the doctor's living, and the inadequacy of medical care, I believe need not detain us. Dr. Hugh Cabot's book *The Doctor's Bill,* discusses the former, and even the somewhat sketchy "research" of the A.M.A. shows room for improvement in the country's medical care as it actually exists.

In attempting thus to outline the swiftly changing conditions that surround organized medicine and medical practice today, I have been somewhat unjust to the medical profession and to organized medicine itself. We must never forget that the very conditions that have altered and complicated the physician's problems are largely the product of his own unselfish and expert work in the fields of medical research and the application of new scientific discoveries. Already, for example, he has entered deep into the field of preventive medicine in a number of the specialties.

Within the ranks of organized medicine certain prophets arose back in the 'eighties and 'nineties with a vision decades ahead of their time. I refer to such men as Emmett Holt, Thomas Roach, and John Morse, in the field of pediatrics, who decided that it was wiser to feed babies properly from the start than to be called upon *in extremis* to watch them die in the convulsions of toxic enteritis. The pediatricians soon learned, and have pointed the way to the medical profession ever since, that the supervision of the healthy was the

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soundest form of productive medical practice.

In May, in Washington, before the Pan-American Scientific Congress, I heard Dr. Paul D. White, of Boston, read a paper on modern concepts of heart disease. Up to a generation ago our efforts went chiefly toward treatment of the recognized heart condition, very little to any study of the causes of the disease, practically none toward efforts to prevent these causes. The reversal of this traditional attitude during the past fifty years has transformed the cardiologist from the plodding slave of digitalis to a leader in the field of preventive medicine.

In my early days of practice, we orthopedic surgeons gloried in the osteoclast after bones had been allowed to become deformed. Now we are internists preventing deformity with cod liver oil and sunshine, and applying only an occasional brace.

These are but random samples of organized medicine's rapidly changing point of view. With its sera and vaccines and various immunological resources, it has entered the field of preventive medicine and public health. I cite these instances to indicate that we are not reactionary traditionalists at heart, only a bit slow on the pick-up. I cite them further to give point to the following opinion which I believe has weight at the present moment.

The time is over-ripe to discard our outworn terminology, to stop talking about curative and preventive medicine, to use instead the designation " medical care," whether that care is furnished to the absolutely healthy, the mildly indisposed, the acutely ill, or the chronic invalid. The term " public health " should be broadened to mean no longer a specialty in medicine, but to be taken in its literal sense as describing the health status of a community at any given moment and its averages through the years.

As already stated, the pediatricians learned this long ago. I wonder how many of them could continue in practice if they saw none but sick babies. The cardiologist derives the satisfactions of practice from learning ways to keep normal hearts normal. Endocrinologists are engaged in promoting health through refinement in the delicate adjustment of glandular activities which represent imbalance rather than disease. Psychiatric interest centers in mental health. Phthisiologists take thousands of pictures of normal chests rather than await the onset of pulmonary hemorrhage.

Organized medicine complains that the public health service is invading its sacred field of treatment and complains vaguely of " state medicine." It forgets that already it has itself invaded far deeper the field of preventive medicine and that its onslaught has but just begun. Organized medicine will do well to realize that of the diseases which still occur many are preventable and sometimes due to medicine's own ineptitude. Organized medicine should fix its eyes more fervently on the vision of its great idealists: first, the promotion of health; and second, treatment of disease. This is its great responsibility in medical care and it can be achieved best by obliterating the divisive names, preventive and curative, and bestowing the single title, medical care, to both.

What is organized medicine's first step toward this objective? The most effective place to begin is in the undergraduate medical school. A start has already been made, a striking one in New York, for example, where a district medical center has been provided by the public health service adjoining each of the five medical schools, in which thorough training of the undergraduate may be carried out in preventive medical theory and practice. Some other famous schools have already

taken this step. All will follow shortly.

The most effective work will be with the young physicians still in schools. Much, however, can be accomplished by extending to older practitioners the growing resources and opportunities for training in preventive medicine.

A second step is the more generous recognition of the merits, from the patient's point of view, of group practice in its various phases. For the most part, modest salaries in group practice are the rule. But the satisfactions of practice are not all financial. The rendering of service to their fellow men is the first principle of the physician's code. Group practice offers this reward in abundance.

In the abuse of free treatment clinics by patients having the capacity to pay, the doctors have an obvious grievance. On the other hand, in the case for example, where a public health treatment clinic is definitely for the protection of the public at large, as in the case of venereal disease, the physician must remember once again that he is a citizen first, and resolve this controversy in a spirit of equity and fair play for the public weal.

Already organized medicine has approved the insurance principle in the matter of hospitalization of the poor and moderately well-to-do. The time has come when this is in fact no longer controversial if the hospitals are to survive.

Voluntary health insurance has appeared upon the social scene in protean forms. This is a tide which organized medicine could not stem even though it so desired. The misfortune is that sound insurance principles are not more closely observed and that so many attempts are doubtless destined to fail before at last a satisfactory plan develops.

Toward compulsory health insurance organized medicine's attitude remains implacable. I will own to a rather strong doubt in my own mind as to the wisdom of suggestions thus far offered. It seems to me that there is an inherent evil in any compulsory scheme that includes only certain classes of those economically entitled to the service. It seems to me that a federal plan of compulsion in a country of so divergent characteristics as our own is beyond human power to administer. Regional or state-wide schemes on a trial basis would appear to be more logical. This is only one man's opinion and I still believe that experiment should continue, and only hesitate at going off the deep end instead of approaching the problem through shallower water.

Organized medicine's responsibility in medical care would be easier to define if all federal bureaus dealing with the nation's health were brought under a single department, such as a Ministry of Health. The A.M.A. would achieve a clearer definition of its advisory position in the fields of research, demonstration, and medical economics. Broadly speaking, it could occupy a relationship toward a federal department of health which the American Public Health Association occupies toward the U. S. Public Health Service. The tranquility which reigns in the latter relationship should be easy to develop in the former. Government endorsement of advice based on A.M.A. research would add to its weight and value.

In conclusion, organized medicine has travelled a long road toward assuming its responsibilities for medical care since it yielded, a bit unbecomingly, to its first irritation at the sensational revelations of the study entitled "The Costs of Medical Care." Much of the sound and fury has subsided. Organized medicine has emerged from the controversy not so badly off. Little by little the early attitudes of the House of Delegates have softened until now the platforms of the two schools of thought find daily less to keep them apart.

The health of the people is the first duty of government. The skill through which alone that health may be assured is in the hands of the trained members of organized medicine. Any act on the part of government which limits or thwarts that skill is not in the service of the people. Recognition of a common aim must be the guiding principle for a complete reconciliation between the two agencies. A first step in such reconciliation will be taken when both realize that medical care includes both curative and preventive medicine and that the two, if not identical, are at least homologous twins.