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**ORATION: The Doctor's Dilemma - Villain or Victim**

I would like to thank the Worcester District Medical Society for this opportunity to serve as the Annual Orator. I am both proud and humble as I recall some of the speakers who have preceded me. I hope that I will be able to do as well as they have. This year is the twenty-fifth anniversary of my graduation from medical school and the twentieth year of my entering the practice of medicine in Worcester. The last twenty years have been a time of rapid change in our nation as well as in our profession. Changes which sometimes have been subtle and gradual and other times sudden and explosive. Men have walked on the moon, and a medical school came to Worcester. One president of the United States was assassinated and another resigned. Coronary artery bypass surgery has become part of the daily surgical procedures in some hospitals but unfortunately so has malpractice. Air travel has become so common that children are urged by television personalities to ask their parents to take them on expensive trips to California, yet the cost Medical care is considered too high. A heated astrodome was built that cost millions of dollars: for football games and other athletic events, but hospital buildings are too expensive. New automobiles can cost as much as a year's salary for the average working man but health insurance still is too expensive and costs 10% of one's income. Times have changed and we have lived through the changes. I would like to examine with you some of these changes looking at medicine in the past, at the present, and the future.

What after all is an oration? It is a speech given in public assemblies and could be an exhortation. An oration is rendered at political gatherings. Orators hold forth at celebrations and times of sadness. Orations are given at retirement testimonials and at the launching of new ventures. Our medical society is indeed in the midst of all of these. We are publicly assembled, we must exhort ourselves to continue our traditions of service despite our detractors, some of whom may use us for their political ends. We are entitled to feelings of celebration as we look back at our careers, but yet we are sad as we remember our deceased colleagues. However, first and foremost, we must view the practice of medicine as a venture replete with new and exciting challenges and if we recognize that our primary gratification must come from the maintenance of health and the prevention of suffering of our patients we shall continue to merit our nation's good will despite our detractors' criticism. There need not be any dilemma if we remember this and view our lives as dedicated to this service.

Who after all are these doctors who are at once damned and deified -where did we come from? To begin with most of us are the spouses, brothers, sisters, cousins, uncles and relatives of those who would damn us. Many of us were, at this time in our history, the children of depression who saw a nation reeling from ill health, poverty and hopelessness. We saw the long lines of the sick waiting their turns in city hospital clinics for treatment of illnesses that were brought on by poverty, nurtured by community neglect and aggravated by the ignorance of the sufferer. We saw physicians struggling to treat diseases that were beyond their capabilities to cure. Many of us are children of immigrants who came to this county to escape religious and social oppression. Our parents were laborers, small shop-keepers, clerks and a few of us are the children of medical practitioners who toiled against tremendous odds to help their patients.

The practice of medicine has often been considered by observers of American society to be the greatest guaranty of upward mobility and so it has been for many of us. None the less, the reasons for undergoing the long years of training, the arduous years of education, the separation from family and friends and the years of postponement of gratification are complex and different for each of us. When asked by the entrance interviewer at medical school about my own reasons for wanting to become a physician, I responded by saying that I liked the physician's life style. This meant a great deal to me at that time and still does. Even in the days of the great depression the physician was an individual who earned the respect and admiration of his fellows. I recall vividly not being allowed to visit the family doctor unless I were properly bathed and attired. In any company, the physician commanded respect and honor. The physician was an imposing figure - you usually felt better in the knowledge that he was on his way. A fresh pot of tea or coffee was prepared for his arrival and the kitchen chair he chose to sit in was carefully dusted. The physician made an adequate living but was usually not as affluent as the local banker or merchant prince, yet he lived well. First and foremost, here was a way of life that any thoughtful adolescent could strive for. You were recognized as an educated person, looked to for counsel in times of trouble, depended upon in times of sickness and in addition you earned a living doing something that made you feel good.

For many of us, our emergence into the practice of medicine was delayed by service in the armed forces, for some it was World War II. For others it was Korea, and for a few of us it was the tortures of Vietnam. For me, it was World War II. I arrived in Worcester about twenty years ago.

Things were different in Worcester then-in some ways simpler and better - in other ways more complicated and worse. There were no H.M.O.s, P.S.R.O.s, medicaid and medicare. But there were hospital staffs whose membership was sometimes more dependent on compatibility of race and religion than on one's capability and credentials. If you weren't lucky enough to get on a hospital staff, you did the best you could to treat your patients by yourself often relinquishing their care to the fortunate ones who had hospital privileges. In addition, as solo practitioner you lost the opportunity for the daily stimulating interaction that comes from contact with colleagues in hospitals. The University of Massachusetts Medical School had no doubt been thought about but not very seriously. There was one small group practice in town but the solo practitioner was major provider of health care. The primary care doctor was still called and proudly so - a general practitioner who needed the specialist only once in a while. House calls were made and the physician's travels through all parts of town were usually made without fear. The golden era of medicine was coming into its maturity. The physician walked the land like a giant Science and technology were making him a saint. The psychotropic drugs followed the antibiotics in freeing our patient from the chains of illness. Later medical pioneers dared to invade the cardiac cavity and restore full breath of life to patients whose existence seemed destined to confinement and limitation. Hospitals were built and rebuilt coronary care units followed intense care units. Nothing was too good or too expensive for the patient and the doctor. Scientific advances demanded the attention of press and public. Research was everywhere. A grateful nation waited anxiously for the discovery of each new technical advance, drug or surgical procedure. Physicians soared in stature and in the popularity polls. Malpractice was a word infrequently used. But why has the saint become a sinner?

The medical euphoria of the fifties and exciting scientific advances of the sixties slipped into the cynical skepticism of the seventies. Where do we exist as a profession today? Is the physician the villain or victim of forces beyond his control? The physician in late 20th Century United

States is depicted in a variety of ways. His esteem as a member of a professional group, although still high, is said to be dropping. Yet, when pressed, individual patients have a very high level of respect and admiration for their own physicians. In one of the media television, the physician is usually portrayed as a dedicated hard working altruistic healer. In another of the media, the newspapers, evidence of malpractice and medicaid fraud make the physician appear to be a heartless, avaricious charlatan. Political figures place their lives and those of their families in the hands of physicians without question. Yet, these same politicians accuse physicians, as a group, of being frauds, and in need of government control. The doctor is permitted entrance into bodily orifices previously deemed too dangerous. Yet, daily, one reads of physicians whose competence is challenged by malpractice suits about the simplest procedures. Are we victims or villains? Are we saints or sinners? The answer is probably that we are both.

We are villains and victims in that we have permitted ourselves and our allies to endow us with qualities beyond humanity. We have allowed ourselves to accept assignments physically beyond our own endurance. An exhausted physician or surgeon cannot perform at his or her best level and subsequently the most capable of us have made tragic errors of judgement and technique. For these errors we as a profession must share the responsibility with what may appear to be an insatiable doctor-consuming public. For most physicians this overwork has been due to their efforts to meet the needs of their patients. In this regard we are the victims and the villains at the same time. We must learn individually and as a profession to discipline our energies and time, for the fatigue that comes from service can be destructive to both patient and physician and can lead to malpractice and poor judgement.

In addition, other problems have arisen which complicate the life of the physician. The third party payment system has often buried him under an avalanche of paper work. Furthermore, as is often the case with intermediary payment systems some of the finer components of physician patient relationships have become endangered. Unfortunately, much of the paper work and forms that have to be completed endanger the privacy and confidentiality of the patient. Following the new Golden Rule, which is he who has the gold makes the rules - patients records are now often open to review and examination by the agents of the third party payers. Naturally, it is to be expected that anonymity and confidentiality will be preserved as much as possible but in many cases this is not possible. I often wish that the obvious benefits of the third party payment did not have to be accompanied by the loss of some of the personal relationships between physician and patient.

However, there are some of our colleagues who, because of personality disorder or mental illness, have viewed their services to patients as a means to satisfy their own needs to become wealthy. They have over-charged, undercared, over-operated and have not understood the anguish of human suffering. They have displayed themselves and their families in awesome ostentation. Their affluence gained because, of the misery of their patients, has been worn like an affront to these same patients. One would hope that the stories of selfish, careless physicians whose hedonism exceeds their healing were not true. Unfortunately, too many cases exist and have been brought to light where physicians' incomes reach preposterous heights for us as a profession to deny. There are a few whose major interest is in the production of high incomes and not in the maintenance of health and sadly, too often, high income and incompetence accompany one another. Here we have been the villain - we have not, at least up to now - monitored ourselves. As a result, in part, of our own reluctance to deal with physician misfits, stories of physician malfeasance have burst into public view in a manner that brings shame to all of us. We have protected our villains and shielded them. The results have been disastrous for

both patients and physicians. Even now some physicians who are called upon to participate in panels to evaluate their peers tend to avoid this responsibility. Fortunately, however, many other physicians recognize the humanity of their colleagues and do serve on such panels. If we do not accept this challenge ourselves, we may forfeit yet another opportunity to escape non-medical control.

Yet, I would not want to imply that physicians should not be well paid or that they should not live well. Indeed, one should expect that a physician's financial rewards would be high enough to make it possible for the physician's own children to attend college and medical school if they so desire. However, a physician is given the opportunity to achieve levels of gratification and pride of accomplishment that is granted to few human beings and if financial reward is of more importance than that - our profession is indeed the villain that our enemies say it is. The physician has the rare privilege of sharing the physical and emotional intimacies of other human beings. The physician can lead a life of continuous intellectual stimulation. Surely, these considerations should be foremost in the life of any physician. We must strive to eliminate from our ranks those whose major interest is in dollars produced rather than in pain and suffering relieved.

Partially as result of the abuses of a few physicians, nation as a whole, has come to lose trust in our ability our own professional integrity. Therefore, in response to these abuses all physicians now find themselves subject to scrutiny. The medical audit, peer review, and Professional Standards Review Organizations now focus on the quality of care delivered in hospitals and soon ambulatory health care review will be part of our professional lives. Fortunately, at present, these reviews are done professionally, discretely, and under honorable medical supervision. Nonetheless any review is only as good as the reviewers. We must continue our high level of honest self-examination or, indeed, we will lose control of our own destiny.

In a similar fashion, in part, due to our own failure to act, an angry public is beginning to demand and in some places require mandatory documented continuing education. I would hope that our critics' view of us, as golf-playing stock market manipulating, greedy pleasure seekers is distorted. Most physicians, I know, spend a good deal of their time continuing their education. They do it, and have done it, to improve their ability to care for their patients and not to accumulate categorical credit. Enforced attendance at educational activities, relicensure and recertification exams may help, but they will not ensure that any physician really cares about his patients. Hopefully, these new requirements will weed out some of our delinquents but I'm afraid the side-effects may imperil the cure.

What may be some of the side effects? In a country besieged by a serious shortage and maldistribution of physicians, we may find that many physicians will spend increasingly larger proportions of their time completing forms and writing up their records in painful detail to avoid malpractice suits. The physicians' time is limited and the hours spent in meticulous documentations only for administrative examination, may take time away from patient care. Naturally we all know that good patient care requires, written histories and physicals but what may develop is a tendency to record just for the record's sake. Also, the requirements and categorization of continuing medical credit gathering may impinge on time that could be devoted to patient care. Furthermore, there already exists a clustering of physicians in and around medical and urban centers that will be aggravated by the need for formal didactic educational requirements. Unless ways can be devised for the medical centers to come to the rural practitioner, the rural practitioner may go the city or have to take time away from his patients to accumulate the necessary documented educational credits. The physician is under siege to be all

things to all people and the subsequent fragmentation may result in a battered doctor. We must search for solutions to ensure high quality medical care and still allow our physicians to pursue their needs for continuing education and even allow some time for rest and relaxation.

Our country has reached a period in its history when it is examining closely the costs of all services. In this regard medical care has not escaped this scrutiny. Physicians have been accused by many of not being interested in cost effectiveness. In a recent study it was pointed out that the "annual physical" is not "cost effective" since the number of hidden ailments discovered is quite low. However, I would ask that cost accountant who made that judgement how cost-effective it would be if it were his hypertension, glaucoma or early malignancy that was the one in a hundred discovered. We have been accused of being responsible for the creation of too many hospital beds. Yet, again, if it's your loved one who is unable to be admitted to a hospital during an epidemic you really don't care about how long the other beds have been vacant. If it's your child who is using the city's extra hemodialysis machine the question of cost-effectiveness becomes quite secondary.

Indeed, it may be fallacious to think of medical care or illness as being cost-effective. It just isn't. Health and disease are no respecters of computer projections. Naturally, we should all try to keep costs down. Waste, is wasteful in health-care as well as in household management. However, could we not view our hospital beds, medical equipment and physician's skills as we do our fire-fighting equipment? We pay for the best in fire engines and maintain them at the peak of efficiency but we are overjoyed if we don't have fires. Why couldn't we feel this way about disease fighting equipment?

Usually, at this point somebody will say that 8% or 11% of our incomes or untold billions of dollars are spent for health care and we just can't afford it. To these people, we must put the question as to how much of our incomes goes to alcohol, baseball, cigarettes and entertainment. If we pay \$15.00 - \$25.00 for a theater or football ticket can we not afford a \$20.00 doctor's bill? No one complains if they pay twelve dollars for a bottle of scotch but do complain about the price of penicillin tablets. Should our citizens who pay thousands of dollars yearly for season hockey or football tickets complain about a health insurance annual cost of one thousand dollars? Are we not confusing some of our priorities?

As one drives through the city and sees the large billboards-advertising the luxuries of life and sees the great big expensive vehicles that transport us from place to place and then comes to view the pain and suffering that occurs in our hospitals, one cannot help but wonder if we are not a nation or a people who are overwhelmed with a need for creature comforts but are not really sensitive to the sufferings of our fellow human beings? Should we not be willing to pay larger taxes for automobile travel, for smoking tobacco, and alcoholic beverages if we knew this revenue would help improve health care through grants for medical research and education?

Recent medical reports have spoken about the limitation of medical resources and the need to select more carefully those who would benefit from these resources. I, for one, would like to believe that we are a people sufficiently endowed with kindness and compassion so that all of our people can benefit from medical advances.

Is a physician a villain if he chooses to sweeten the last hours of an elderly patient? Are the last years of life more expendable than any other years? Yet, cost effectiveness experts would suggest that procedures which are expensive should be reserved for the young. In recent medical literature, much has been written about how medical care shall be apportioned. The high cost of life-saving cardiac surgery has caused some writers to wonder for whom it shall be performed. It would appear to me that the humane physician would be a villain if he chose to offer his skills to

any patient based on what was thought to be a patient's future life expectancy or career performance. Are we physicians going to be the victims of a dollar-demented bureaucracy that will determine the value of human life in terms of product delivery systems? We have been called vendors and we deliver services to consumers. We must remain physicians who take care of people and put their needs first.

We have, however, neglected some of our responsibilities. Perhaps, it is because we have devoted all of our energies to patient care or, have we simply not cared enough? We have considered too often that the political process was too dirty for us. We have reacted too often and acted too infrequently. We have given our detractors too many opportunities to enact laws that we knew would be detrimental to patient care. We have shunned organized group medical activities and complained about the A.M.A. and our own district medical society. At the last Worcester District Medical Society meeting forty members voted a budget item twenty-three to seventeen. Yes, doctors, forty physicians voted a budget of close to fifty thousand dollars for a medical society of four-hundred and eight members. We certainly are the victims of our own villainy if we behave this way and show the public that we have no interest in running our own affairs. We have abdicated some of our responsibilities by allowing too few to speak for too many.

Of course, none of us like the convoluted, argumentative procedures of medical politics but it is the medical societies that have been and could be our strength. We must make it possible for our younger members to express themselves and encourage their membership. It would be great if we could stick to our science and healing but medical care delivery has become a complicated process. If we are to avoid being both victims and villains we must join together in our concerns about medical care issues. We cannot expect any longer to do it alone. Educated non-physicians are eager for our help. They have recognized the needs for improvements in health care. They appealed to us for help and, too often, we have taken an elitist position and have not been as cooperative as we could have been. Consequently they have done it alone with what we as physicians have considered unhappy results for all. In addition, there has grown up an entire coterie of people called health care specialists. These are individuals who have developed high levels of knowledge about the delivery of health care to large groups of people. They have become the health care planners of our time, they have devised methods for provision of such care to our patients. Unfortunately, we as physicians have not chosen to join them and, therefore, we have given up our prerogatives to those who may be experts in the demographics and economics on health care but not the humanity thereof. The health care planners cannot understand as we do the pain and suffering of human beings in the grips of illness. It is our obligation to participate not only in the direct delivery of health care but also in the planning process with other experts.

There are two tasks. We must unite and bend our efforts anew to the problems of assuring the best health care to our patients. We cannot devote ourselves exclusively to improving our techniques without paying attention to whom and how our technical abilities are delivered and at what costs. If we are to be true and Complete physicians and not technicians we must view the patient in his/her total environment. Further, we must join our non-medical colleagues in their efforts to improve factors beyond our control in the treatment of sickness. We must recognize that the sociologists, economists, environmentalists and the politicians have high levels of expertise in non-medical areas that can help us to help our patients. In the past we have followed, now we must try to lead - let us hope that it is not too late.

The doctors dilemma - villain or victim? We have been both. Most of us have tried

desperately to serve our patients but we have not been assiduous enough to remove from our ranks those physicians whose motives are open to question. We have not cried out when our country complained about costs of medical care and pointed out that we will always be careful of expense but never cautious about health. We accepted criticisms about cost effectiveness without concern for a nation that spends billions for munitions, alcohol, tobacco and amusement. Some of us have suggested that our health resources should be distributed based on some formula of life expectancy or performance rather than stand firm on the priceless value of each human life. We have been villains when we have refused to join others in efforts to eliminate environmental health hazards but have been victims when others have expected us to care for their health needs and their environmental concerns without regard for our own health

What will the physician of the future be like? As one reads the signs it is hard to visualize that the solo practitioner who maintained his own individual office and style of practice can continue to exist. The tremendous mass of knowledge that has accumulated in the last quarter of a century makes it impossible for any one individual to be able to provide total health care. In addition, the requirements for ancillary personnel such as nurses, laboratory technicians, social services and pharmacological assistance would make it also wiser and more economical for the physician to practice in some kind of group. Indeed, the government has already indicated that this would be its preference. It has taken special pains to provide extra funding for group practice and H.M.O.'s but given little encouragement to the solo-entrepreneur practitioner. The public dreams of the individual solo practitioner sitting at the bedside of a sick individual but, yet, is unwilling to realize that this individual can no longer function as he used to in the past with the administrative burdens that he must face. The danger remains that that which is cost effective, most practical and easiest to deal with is not always the best nor the most humane. In a similar fashion one must recall that the determination was made by some experts that the best way to house people would be in barracks-style dormitories, yet, this is not the most humane way. In the future, let us hope that people will continue to moderate economy with humanity. In addition, the careful monitoring that is required now by the third-party payer will continue to make it too onerous for the individual practicing physician to continue his private practice style without some assistance and help from colleagues in some type of group practice relationship. Perhaps we can combine the best features of group and individual practice in some manner.

The physician of the future must be a humane, active participant in maintaining the health of his neighbors, be this in direct patient care, community action, peer review or political action. For this the physician will be neither villain or victim but will lead a useful, gratifying, honorable, fairly compensated life, regardless of how health care is financed. The physician of the future must prove to an educated nation that he can be trusted. This can be demonstrated by continued delivery of highest quality medical care with or without supervision. The physician of the future must be dedicated to continued self-examination and education without the threat of relicensure or recertification. If it is supervision that we really need then we run the risk of becoming technicians rather than physicians. The challenge is ours - I know we can meet it.