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Editorial

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Editorial

The More Things Change . . .

We have lived all our lives in a changing world, in a century and in a country where almost all aspects of human life have undergone rapid, radical, and apparently irrevocable alterations. Each of us must sometimes marvel at the breathtaking pace of change in our world. But a moment of marveling is just about all we can manage. There isn't time to contemplate, let alone comprehend the dazzling changes taking place. We live in the midst of many revolutions, not only those brought about by technology (as if space exploration or lasers, robots, and silicon chips were not enough) but also in morals and mores, religion, sexual practices, entertainment and recreation, politics, music, economics, the visual arts, ecologic management, law — the list is endless. Geographic boundaries shift every year, and history is rewritten. For all I know, they may be adding new words to Latin.

Medicine, characterized through the ages as an exciting, enterprising, advancing discipline, is intensely caught up in the kaleidoscopic maelstrom of modern civilization. In medicine, too, the rate of change is accelerating. Physicians, who must be involved with the heavy pressures of caring for patients, cannot be fully aware of everything that is happening in medical science.

Which of us can perceive the ultimate use of the laser in treating the human body? Will the almost unbelievable promise of monoclonal antibodies be fulfilled? Will we really transplant organs as easily as automobile mechanics replace car parts, keeping antique models running long after they have become obsolete? Will we learn to modify and control the fabulous double helix of DNA? *Can* the human brain comprehend the human mind?

We have heard such questions before, and we have fobbed them off for future generations to answer. The game has changed. The answers will arrive in our lifetime, probably in this decade.

The profound changes affecting the medical profession are not merely scientific and technologic. The very road one must travel to acquire training in medicine has been narrowed, obstructed, and will no longer accommodate all who hope to make the pilgrimage. In this issue of the Journal, Dr. Richard Reitemeier, immediate past president of the American College of Physicians, Chairman of the American Board of Internal Medicine in 1979 and of the Accreditation Council for Graduate Medical Education in 1983, describes the shrinking opportunities for graduate medical training in America. After World War II, American medical schools rapidly expanded both in the number of schools and in the size of their classes. At the same time, large numbers of foreign medical graduates were welcomed for training in American hospitals. The costs of this unprecedented increase in medical manpower have been added to the huge expenditures needed to develop and apply new technology, multiplied by social programs designed to ensure optimum health care for great numbers of our people heretofore underserved. As a consequence, the cost of health care in the United States has become prodigious. The result should not have surprised us.

The word is out that health care costs must be reduced. Whatever the outcome of the 1984 national elections, government programs will exert increasing pressures on doctors and hospitals: provide quality care for all and do so at lower costs. How can this mandate be carried out? Something or someone will have to go. Dr. Reitemeier believes that the opportunity for graduate medical education will be one of the first to be eliminated. Already the numbers of residency positions have been reduced, and further major reductions are foreseen, forced by economic considerations.

The now-famous 1980 report of the graduate Medical Education National Advisory Committee (GMENAC) concluded that by 1990 the United States will have 70,000 more physicians than "required." Only a few specialties will have shortages, while some will contain twice as many as the needed number of doctors. Physician overpopulation must inevitably engender competition for patients among established private practitioners. At the same time, a growing number of new group practices and hospital-sponsored community clinics are offering comprehensive care in attractive settings. In response to the many complex problems facing today's practitioners, the American Medical Association developed an admirable guide to help physicians meet these challenges (1). The Department of Practice Management uses this guide to conduct workshops that assist doctors in analyzing and solving particular problems in their communities.

When Richard Endress recently conducted such a workshop at our institution, he compared the gloomy prospects facing American doctors to the grim prognosis given a patient with an incurable illness. Physicians often react to the current situation in a manner very similar to that observed in such patients. The initial reaction of shock gives way to disbelief. When the reality of the situation becomes apparent, disbelief turns to anger, which is followed in turn by depression. The final phase for all patients, according to Mr. Endress, is acceptance, an attitude that makes the best of a bad situation. But if the fatal prognosis is correct, the ultimate outcome is death. Demise is an unacceptable, impossible result for American medicine. After acceptance, our imperative must be to survive, to reorganize, and to restore the system to new health.

How fares Henry Ford Hospital? The institution apparently approaches the mid-80s strongly positioned to cope with these various challenges. By full participation in advancing technology, the professional staff is committed to the applications of nuclear magnetic resonance, laser technology, organ transplantation, and multiple computer applications including the computerized medical record itself. Continued expansion of the Henry Ford Hospital system of satellites makes access to our staff and facilities readily available to most of the population of southeast Michigan. In addition to the one now fully operative in Plymouth, five new small satellites are planned for the very near future, and Lakeside Center will be developed as the fourth full-service satellite.

In addition to the growing prepaid Health Alliance Plan, for which Henry Ford Hospital is the major provider, the Hospital has recently announced the formation of a regional network of community hospitals to provide total medical services to members of a new health maintenance organization (HMO), the Preferred Health Plan (PHP). PHP actually encompasses two plans: Senior Plus, an HMO for Medicare participants which expands Medicare benefits at lower cost; and a Preferred Provider Arrangement, a flexible employee health insurance plan designed to limit the escalating premium costs faced by corporations. Development of the HFH community hospital network has been supported by a $270,000 grant from the Commonwealth Fund.

In developing these initiatives even as it copes with the entanglements of DRGs, Medicaid, Medicare, and innumerable private insurers, Henry Ford Hospital has not reduced its commitment to research, to graduate medical education, or to undergraduate education, especially through its affiliation with the University of Michigan College of Medicine.

According to an old French proverb, the more things change, the more they stay the same. Maybe not any more. The wisdom of old French proverbs may be giving way to the insights of American folk music: "The times they are a-changing."

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Reference

1. American Medical Association. Marketing strategies for private practice. Chicago: Department of Practice Management, 1983.