The Shame of American Medicine—A Reply

In the long stream of vitriol which Miss Langer has poured over the heads of physicians, the following specific complaints are presented:

1. Medical care of the poor is poor.
   A. The fee-for-service scheme and the unpleasantness of clinics discourage preventive medicine and continuing care of chronic disease.
   B. Clinic facilities are inadequate.
   (1) Numerically
   (2) Attendance at clinics requires loss of time from work.
   (3) A patient is shuttled from clinic to clinic and from doctor to doctor.
   (4) Clinics are impersonal and insulting.

2. Physicians
   A. Operate unnecessarily
   B. Take inadequate histories
   C. Perform inadequate examinations
   D. Fail to use laboratory facilities
   E. Split fees
   F. Own pharmacies
   G. Cheat on insurance
   H. Experiment on patients without telling them
   I. Keep expensive equipment idle

Miss Langer's specific solutions include:

1. Replacement of solo practice with teams of specialists in groups.
2. Prepayment plans, including regular salaries for doctors, rather than fee-for-service.
3. Expansion and more efficient organization of hospital services. (This recommendation is not very specific.)
4. "Fusion of now-fragmented health resources—medical schools, hospitals, public and private health agencies—into a coordinated 'health industry team', whereby unified, community-oriented planning would replace competition among hospitals."

The basic problem with the medical profession, in Miss Langer's view, lies in its self-regulation; the public has no control over the practice of medicine. ". . . a doctor performs unsupervised services for unregulated fees."

After recovering from my initial ire at this unfriendly attitude, I have set down the following reactions.

I. Regulation of the profession:

A. *Control of the quality of medical care*. It seems irrational for non-physicians to judge medical knowledge. The public could insist that physicians be repeatedly tested, by the National Board of Medical Examiners, for instance. There is no way, however, to ensure by testing, kindness or genuine interest in patients. Intangibles such as these are still as valuable in the healing of people as is pharmacologic or surgical therapy.

Perhaps dissemination of information about the efforts of physicians in continuing education would reassure the public. I am unable to devise any practical scheme for control of the excellence of an individual practitioner other than those in operation, namely careful selection and training of medical students, including constant exposure to teachers who stress loving care for the whole person.

B. *Control of the cost of medical care*. The threat of direct governmental control of physicians' salaries seems remote. Private enterprise, self-reliance, and the worth and responsibility of the individual are still American ideals. Physicians become understandably irritable at suggestions that they accept government salaries, when others upon whom life and happiness depend, e.g. automobile manufacturers and mechanics, lawyers, plumbers, continue unregulated.

Doctors nevertheless could well heed Miss Langer's expression of apparently widespread resentment (*see* Harris, R., Annals of Legislation: Medicare, *The New Yorker*, July, 1966, for a carefully written shellacking of the AMA), and respond with practical improvements of existing inadequacies.

The fee-for-service payment system does discourage the repeated visits required for optimal care of chronic conditions for which effective palliative therapy is available, for example hypertension, congestive heart failure, diabetes mellitus, chronic bronchitis and emphysema. Unfortunately, the physician's fee-for-service, $5.00, is an insignificant contribution to the cost of chronic illness. Hospital costs, drugs, x-rays, and laboratory tests represent relatively enormous expenses. Medicare and private medical insurance

MCV QUARTERLY 2(2): 160-161, 1966

plans do not cover the cost of drugs, nor, usually, the cost of laboratory tests for outpatients. Comprehensive pre-payment plans whose cost is reasonable should be encouraged by physicians. A reasonable reimbursement for physicians' services for a year, say $85; plus drugs—reserpine, a thiazide, and guanethidine cost about $12 per month—$150; plus chest and renal x-rays, $75; plus four BUN's; three sets of electrolytes, two urinalyses with cultures, one blood sugar, $90; plus an administrative fee for office operations, $25; total cost—$415; or about $35 monthly. To make such coverage available for the non-wealthy would require insurance of a very large number of persons healthy during that year. The community must make such care available; the primary consideration is the most efficient method. Coverage of the entire population by government may be most efficient. Those of us who distrust extension of government must provide efficient schemes, or give reasons more practical than the independence of individual physicians, for avoiding governmental finance for medical care. Blue Cross and Blue Shield are theoretically controlled by physicians, and represent the best hope we have of providing adequate coverage of the cost of chronic illness without resort to government regulation.

Miss Langer's criticism of clinic facilities applies accurately to Richmond, where the city's only general medical clinic meets three nights weekly in the downtown area and is perpetually overcrowded. The appointment system in the outpatient clinics of MCV, where all patients are told to arrive at 8 a.m., noon, or 5 p.m. seems designed to ensure long waiting lines at appointment desk, laboratory, and pharmacy. Public, consumer participation in the planning of outpatient scheduling might well improve service to patients.

Physicians whom Miss Langer knows are a scurrilous group. She has selected examples of physician-failure which are (1) from time past (own pharmacies, experiment without informed consent, split fees, operate unnecessarily), (2) half-truths (almost all fall short of perfect histories and physicals, and I skimp on lab tests to save the patient's money), or (3) are not true, in my experience, (cheat on insurance).

"Replacement of solo practice by teams of specialists" contains an obvious fallacy, which I'm sure Miss Langer realizes, namely, patients cannot be cared for by a committee—one person has to be responsible, and authoritative. Any sensible group of physicians realizes this fact, and it is possible to design a group which is a team of expert consultants available to the one physician who is responsible for the patient. Group practice has such obvious advantages in education, quality control, vacations, and attractiveness to the customer, that one suspects there must be some poorly understood (by Miss Langer and me) truth to explain their infrequency. My guess is that physicians are unusually independent people who by dint of brains and hard work can achieve financial and psychologic success as individuals. They resent interference. By the same process, physicians tend to become supporters of the status quo, scornful of the unsuccessful as lazy, and perhaps even a tad indifferent to the public interest. Voluntary regulation of the profession by physicians genuinely concerned for the interests of the public seems to me far preferable to control by government, since physicians are far better informed about the problems of medical care than is any other segment of the community. It is my hope that physicians individually and collectively will stop senseless opposition and become leaders in providing expert medical care for all Americans.

David W. Richardson, M.D.
Associate Professor of Medicine
Medical College of Virginia