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President's Page

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President's Page



A Crisis of Confidence in American Medicine

One need not be in the active practice of medicine to realize that there is, today, a growing chorus of criticism of American Medicine. An atmosphere of discontent prevails among doctors, patients, government agencies, medical insurance companies, hospitals, and medical education institutions. Most of the criticisms fall within the category of the "iron triad" of (1) rising costs of medical care, (2) limited access to that care, and (3) the uneven quality of care.

The medical malpractice crisis is a reflection of the adversary relationship that has developed between doctors and patients. No longer is the physician trusted and looked upon as a friend. Instead, there is an increasing distrust of doctors for doing unnecessary surgery, owning their own laboratories, owning their own sophisticated MRI and CT machines and giving rise to the suspicion that their own patients are being sent to these facilities more often than may be indicated.

What are the factors that have created this crisis in confidence in American medicine? At the 1989 annual AMA Meeting in Chicago, Dr. Louis Sullivan, secretary of Health and Human Services, declared "Marcus Welby is dead!" He then discussed how massive government reforms have completely altered the way American medicine is practiced today. In addition, with the development of Individual Participating Associations (IPAs), Home Maintenance Organizations (HMOs) and Participating Provider Organizations (PPOs), the independence of the

local physician in governing his practice autonomously seems to have ended, to be replaced by government bureaucracy and mounds of paperwork.

In a recent article, Dr. Harris D. Riley, distinguished Professor of Pediatrics at the University of Oklahoma School of Medicine, outlined some changes in the education of physicians from 1948 to 1988. He presented some interesting statistical data: For example, as in 1948, there were 70 U.S. medical schools with 22,248 students. In 1988, there were 127 U.S. medical schools with 66,000 students. In 1948, 9.5% of medical students were women, while in 1988, 34% were women. In 1948, 60% of those in medical school were unmarried. In 1988, no one exactly knows what the status of students is, except that more are either married, have a "strong, meaningful relationship", or are divorced and now single. In spite of these figures, the number of medical school applicants is declining overall, and this causes some concern as to whether standards for acceptance are being maintained. The inference is that, although there are more medical schools and more doctors graduating, quantity and quality do not necessarily go together.

The medical students of today are exposed to a tremendous increase in the body of existing medical knowledge, in their four-year curriculum. They are exposed, as well, to many more branches of medicine, for example, Biomedical Engineering, Biostatistics, and Computer Science in their four year curriculum, etc. The effort to adapt this expanded knowledge base with changing social morals has created a greater need for achieving a balance between the art and the science of medicine. Accompanying this, a number of serious problems in the medical school curriculum have been identified, most notably the *lack of emphasis on medical ethics and basic concepts and principles governing good medicine.*

Trying to provide quality health care for everyone in a time of cost containment has resulted in limited access to the care. Uwe Reinhart, a health care economist, argues that "if quality health care is a universal right, then it cannot be managed by a pricing supply and demand structure." The recent cut in federal subsidies for state Medicaid and Medicare payments is nothing more than the federal government's retreat from the concept of affordable (subsidized) high quality medical care for all citizens. This further lessens the accessibility to medical care, since many hospitals and physicians have reduced or eliminated the numbers of Medicaid patients they will treat. This limited access has increased the level of frustration for the physicians, the public, and the government, which in turn contributes to the loss of confidence in American medicine. A more acceptable answer to cost containment would be to reduce the duplication of facilities and to seek more cooperation between government and private hospitals.

In the meantime, the explosion of medical technology in recent years makes certain procedures, quality care, and the demand for a perfect

result in every case commonplace expectations. Unfortunately, the high level of technology has by far outgrown our ability to pay for it and our capacity to make it available for everyone. This increases distrust not only of American medicine in general, but also of the individual physicians who apply these high technology treatments.

The relationship which once existed between the patient and his doctor, i.e., total trust by the patient returned by total honesty on the part of the physician, must be restored. The problem is how to best do this. Since lack of emphasis on medical ethics in medical school curricula has been identified as a problem, further study in this area is certainly worthwhile.

The medical ethics agenda in most medical schools (and hospital Ethics Committees) presently focuses on general subjects such as the abortion issue, euthanasia, patient disclosure in research projects, organ transplants, informed consent permissions for surgery, etc. Each of these subjects needs understanding and is worthy of consideration. However, the question that seems to arise from the public, from Senate hearings, and from newspaper articles is this: When is the medical profession going to tackle the problem of the *individual's* medical ethics? The prevalence of high technology in medicine now requires subspecialization, so that today a multitude of doctors may take care of a single patient. This, in addition to the paramedical and administrative personnel who also get involved in the process of delivery of medical care, puts the patient miles away from "his or her doctor." The unfortunate end result is that often the patient does not know which one of the physicians is in charge of his care, and the physicians frequently know the patient not by name, but by case number only.

The current emphasis on the more general areas of medical ethics is important, but the emphasis on the specific ethics of individual medical students is the key to restoring the total trust of the patient. Perhaps Admission Committees must stress the importance of the character, integrity, and moral fiber of candidates for medical school (and intern, resident and staff candidates) more than the GPA or MCAT scores.

The challenge, then, is to renew the trust the public (and the government) once had in the health care system. This must be done by re-emphasizing high standards of medical ethics in the individual physician. The practice of medicine and the delivery of health care must once again be treated as a profession and not merely as a "provider of routine, equal, universal service". The individual physician must regain the right to exercise independent judgment according to what is best for each patient rather than what fits best in the HMO-PPO-Medicare-Medicaid criteria. Not every patient is the same, with the same risk or needs. Not every appendectomy is the same. To apply cookbook or laundry-list principles in the discharge of medical care is completely irrational. The public must release this aspect of care to the physician. Conversely, the public has the right to expect that once its trust is violated, a meaningful action will be taken by responsible members of the medical

profession, rather than having them “look the other way.”

It is hoped these reforms will begin at the beginning — in the medical schools — and will be applied throughout medical practice to ultimately restore the public’s confidence in American medicine.

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References

1. Riley, Harris D. Jr., M.D., “Reflections on Changes in the Education of Physicians from 1948 to 1988.” *Houston Medicine*, Vol. 5, December, 1989.
 2. Henke, Cliff, “Is Marcus Welby Dead?” Hospital Satellite Network and Physicians Radio Network (HSN-PRN) *Program Guide*, January, 1990.
 3. Vara, Richard, “Medical Advances Raise Moral Issues: Doctor”, *The Houston Post*, March 18, 1989.
 4. Keyser, Herbert H., “Stronger Medical Ethics Needed for Patient Trust”, *The Houston Post*, Nov. 9, 1989.
 5. Watson, Andrea, “Physicians Put Practice on Market — Doctors Find They Must be Businessmen.” *The Houston Post*, March 13, 1988.
 6. Golenski, John D., “Providing Quality Healthcare in a Time of Cost Containment”, *St. Joseph Medical Ethics for the Physician*, Vol. 4 No. 3, July, 1989.
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