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Alphonse M. Schwitalla

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Alphonse M. Schwitalla, S.J.

Dean, St. Louis University School of Medicine

I.

MEDICINE enters 1948 bewildered and dazed. In every respect, in research, in education, it has reached climaces. Medicine does not know whether these peaks in their upward trends are simply intermediate peaks, or whether they are true terminal maxima presaging a downward trend. Its self-development through its research has forced medicine to accept larger responsibilities, has introduced complexities into practice and revolutionary modifications into the schedules of our schools of medicine. With these changes, the schools have been forced into undergraduate programs of larger comprehensions and into graduate programs requiring the most minute specialization. The faculties of the schools have been forced into more and more comprehensive activities and the practitioners of medicine, into an examination of their own professional conscience, into formulation of their attitude toward new medical procedures, toward the new auxiliaries of medicine, but most of all toward a new discriminatory evaluation of the doctor.

At no time in the history of medicine has there been a period of greater upheaval of attitudes than the period through which we are passing. If economists, sociologists, historians, psychologists are speaking of the evolvements of the Atomic Age, then surely medicine too, as it studies itself must join in the volcanic eruptions of self-evaluation, of self-criticism and planning. The scientific discoveries of the last decade will make it impossible for medicine ever to see itself again as it was in 1940. The content of the medical curriculum has embraced huge areas of social, economic and historical thinking, which areas a decade ago were for medicine objects of observation and quiet study, but by no means factors in influencing dynamic upheavals. The areas of medical

practice have been enormously modified by the changing viewpoints of both the medical person and of the so-called "consumers of medical care." All of this is more or less trite and axiomatic in these opening years of the new Atomic Age. What is not axiomatic and trite is the new responsibility which all of this demands of medicine.

The responsibility is the true measure of a man. Not knowledge, not activity, not influence, as such, are the true measures of the physician. His assumption of responsibility *is* a true measure.

The implications of psychosomatic medicine are symptomatic of medicine's readiness to accept and to implement the changes in ethical attitudes, as are also the integration of psychiatry and organic medicine, the interpretation of disease in terms of social environment, the extension of public health viewpoints into the areas hitherto restricted to personalized medicine, and the planning for a world medical association. If some of these developments are still characterized by their natal enthusiasms, they, nevertheless, already afford evidence of medicine's ethical readiness to assume the responsibilities emerging from the new conditions.

There has been an enormous change in the philosophy of medicine and of medical practice. It is incumbent, therefore, upon all of us to face the situation with unqualified sincerity and searching penetration.

There are literally thousands of areas of medical interest which might be chosen as the starting point of an evaluating discussion. Let me, however, suggest as a starting point, the attitude of the medical profession towards itself.

II.

No other profession, except of course, that of the sacred ministry, has as elevated an opinion of itself as has medicine. One of the chief reasons for this fact is that as the student of medicine progresses in his preparation towards professional standing, the intrinsic dignity of medicine becomes continually more and more impressive to him. The dignity of man, the essential privilege of giving service to man, the paramount respect which one gains in the practice of medicine for human individuality, the appreciation of both human weakness and human strength which develops in the mind and heart of the thoughtful physician as he comes into the widest contacts with human beings, all these produce in the doctor almost inevitably, a wonderment concerning his patients, akin to the hero worship of the adolescent boy and his emulation of his hero's greatness.

As the physician grows in the admiration of his own profession, he becomes, if he is truly a doctor, increasingly aware of the honor and glory that are his in caring for the human being. But with this admiration, there must also grow in his soul, his appreciation of his own responsibilities. He must become more keenly aware of the vast significance of his privileges and he must differentiate between those privileges and the privileges enjoyed by others whose service to mankind is less intimate and less influential. Throughout the ages, medicine has kept as a sacred trust this grand responsibility committed to itself. When medicine rose to its opportunities, the evaluation of physicians was high; as medicine passed through periods of lethargy its sense of responsibility diminished and at times even all but disappeared, especially in those days when the spirit of investigation had all but disappeared and when for decades and parts of centuries at a time, medicine lived on its reputation without adding greatly during such periods to the self-evaluation of the physician.

During the periods of medicine's ascendency, medicine acted as a guide and counsellor of mankind. There were periods when medicine found itself identified with man's highest ambitions for mankind and in those periods, there were accumulated reserve resources of strength and responsibility, which carried over into moments of professional depression when medicine for one reason or other failed to achieve a full appreciation of its own greatness.

What is our situation at the present time with reference to the profession? No charge is more frequently made than this: that medicine has no uniform and unanimous attitude towards its own responsibilities.

There is no purpose in laboring the point, or giving extensive discussion to its consideration. Will it ever be possible from this time forward, for mankind to agree with complete unanimity on any basic concept? When we apply this skepticism to medicine, however, we are led to far-reaching considerations and fundamentally to far-reaching programs of action. It is true that medicine has enrolled among its votaries today, men of the supremest idealism, but medicine has also been accused by interested members of the profession as well as by the public, of having reached the very bathos of its own self-depreciation and its irresponsibility. It is pointed out that the old-fashioned, time-tried, basic attitude of medicine towards itself is fundamentally, that the relationship between the physician and patient is unique among human relationships. The newly emergent conclusion, however, makes medical care a commodity like any other commodity that is distributable to all the units of a given population, with no more discrimination and difference in the rendering of that care than is demanded by the character of a particular illness. In other words, variability in medical care is dependent not upon the receiver or giver of medical care but only on the processes employed in giving it, very much as is the case with the product of a complex machine, or a group of machines, each of which mechanically and without discriminatory choice, makes its contribution to the conveyor belt of an assembly line.

The resulting struggle in medicine, between emphasis upon individuality of the patient, on one hand, and upon allegedly so-called social influence, on the other hand, roughly separates physicians into two major groups. One would think on the basis of medical history that physicians should be found on one side rather than in both of these contrasting groups, but today, as a matter of fact, physicians are not only actually to be found in both sides of this argument, but the number of physicians on the side of "socialized medicine" is increasing. Those physicians who boast of their "social" attitude complain of the backwardness of medicine, the horse-and-buggy attitude. On the other hand, the adherents of the dignity of the physician insist that there can be no social values in medicine unless individual values have first been safeguarded. There are, of course, hundreds of shades of difference in the opinions of these two contrasting groups. As we enter upon 1948, there is ample reason for asserting that the number of physicians led by social philosophy is really increasing faster than those who have shaped their professional lives within the framework of traditional attitudes.

We might attempt to illustrate our point by a brief consideration of a contemporary problem. Medicine was content a few years ago to endorse Blue Cross plans under the supervision and the sponsorship of medical societies, but medicine was not ready to endorse the Blue Shield plans. Today, medicine is being called upon not only to endorse the Blue Shield plans, but also at times and in some places, to endorse the amalgamation of Blue Cross with Blue Shield plans. It is fully recognized that in securing such an amalgamation, the basic concepts underlying these plans had to be modified to meet the exacting demands of ethical medical practice. But the question is, was the amalgamation really achieved without sacrifice of principle in medicine?

The hospital care given under Blue Cross has tended more and more completely towards averaging conditions in hospital service. The Blue Cross of itself does not tend to promote superior excellence in hospital care. Can we expect that the Blue Shield services will be any more successful in promoting the doctor's ambitions in achieving distinction in his practice? The moment has come when physicians themselves are asking whether or not the drift towards average mediocrity, which drift is inevitable when we are dealing with tens of millions of subscribers, can possibly be in the last analysis, in the best interest of the patient. I know that pressures are being brought to bear on Blue Cross to give to the subscribers a choice of various levels of adequacy in hospital care. Blue Shield plans have attempted, more or less successfully, to steer a course paralleling that of the Blue Cross plans. Voices have come even from the high places of medicine pleading with the profession to yield to social pressures and to harmonize the contrasts between the physician-patient contract, on the one hand, and the hospital-patient contract, on the other hand, through economic considerations ignoring the underlying basic philosophies. It may be feasible to plan differential levels of adequacy in hospital care; but what differential levels of medical care could possibly be justified?

After all, what objection is there to furnishing both medical and hospital care through one contract between Blue Cross and the subscriber? It cannot be denied that administratively the scheme can be made to work if one considers only the more or less factual and objective aspects of such a contract. On the other hand, there are enormous differences, intrinsic as well as extrinsic, between the physician-patient contract and the hospital-patient contract, which differences, in my opinion, are large enough to constitute a real impediment to the inclusion of both medical and hospital service under one contract. There is a growing demand for approximating actual hospital costs and charges to the patient, the implication being that while the hospital should not be a surplus producing agency, it still has a right to full remuneration for costs from the patient. On the other hand, it is also conceded very generally, that the physician-patient relationship cannot be evaluated in terms of costs and should not be evaluated financially through any other considerations than the patient's welfare and the patient's capacity to pay. As far as financial considerations go, the difference in the charges made by the physician against the patient should be ideally determined by no other consideration than the patient's needs.

We might, of course, continue our analysis of the differences between the physician-patient contract and the hospital-patient contract into many of the highways and byways of hospital and medical practice. Such an analysis would yield a deeper insight into the significant differences between the two contracts. There would emerge practically only a single great similitude between them, but that similitude would be based largely, if not entirely, on the patient's ability to pay for the care that he is receiving. In this connection, I desire to emphasize one of the outstanding phenomena that has come under my notice with reference to the attitudes of a patient. If he has only a limited capacity to pay for his medical and hospital care, he seems content, probably by reason of innate instinct, to pay the hospital rather than the physician. The patient himself somehow feels that his puny contribution to the costs of his illness is capable of paying for hospital care rather than for medical care. Moreover, the physician accepts implicitly this attitude of the patient and thereby contributes ever so effectively towards diffusion of medical care.

Another consideration which must not be overlooked is the attitude of physicians towards their own practice that it makes very little difference who pays the bills. Formerly, the payment of the bill by the patient was regarded as a part of that *quid-pro-quo* which the patient renders

to the physician for the latter's care. Very recently, a prominent incumbent of a high place in medicine insisted that the physician-patient relationship in no sense includes the source of the funds through which a doctor maintains his professional standing. As a matter of fact, however, the source of the remuneration dynamically involves the inter-relation between physician and patient. It would lead us too far at this point to analyze these implications and to insist again that in accepting the remuneration for medical care, the physician has a right and an obligation to know whether payment for medical care is recognized by the patient to be an expression of his only partially met obligation towards his physician.

The suggestion has been made even by practicing physicians that a voluntary levy of ten per cent upon wages in large corporations can yield enough to pay for the costs of hospital and medical care. The excuse given for such an attitude is that the workingman must be encouraged in his desire to pay for his medical care so that we may render medical and hospital care to the patient not as a "charity" but as a social right. This attitude, needless to say, is an over-simplification of the problem, and the alleged "factualness" of such an attitude is one of the most discouraging features in our attitudes towards care for the sick. In such an attitude, there seems to be a complete absence of idealism. The statement itself gives the greatest reason for caution and reasonable skepticism.

Another source of concern is the growing administrative domination of medicine by lay authority. There is thus lost to the physician his idealistic attitude towards medical care as a service rendered to the patient by the physician. Relatively few lay persons can adequately penetrate into the intricate idealism of medical care. There is an enormous difference in administering medical services and almost any other kind of welfare services. The criteria which is most important in this connection is the immediacy of the help rendered to the patient by the physician. Those who are trying to keep the attitude of the people towards medical care upon an elevated basis do so by encouraging them to cultivate to the highest degree, a freedom of choice of the professional and social helps rendered by the medical profession, thus leaving responsibility for such a choice where ultimately it must rest, just as the responsibility for the choice of any of our available cultural factors must remain as a prerogative of a citizen. Here again, the medical profession can make donations of its services without, on the one hand, making the patient an object of misplaced charity, or, on the other hand, making the physician the grantor of unjustifiable professional largesse.

This hurried analysis, needless to say, does not exhaust the numerous unmentioned criteria of medicine's attitude towards itself in the giving of medical care. It does, however, meet some of the recently expressed

attitudes towards the changing viewpoints. The experience in England was a tremendous revelation to the members of the profession itself. The profession objected strongly against the legal impositions. When the date arrived, however, for the new law to go into effect, the physicians yielded to the public pressures and continued to give medical care to those who needed it without being concerned too much about the legal implications. At first the British physicians voted against having anything to do with government medicine. The vote is said to have been roughly four-fifths for one-fifth against the continuation of the private practice of medicine. But when the date approached for the inauguration of government medicine, the ratios of those for and against government medicine were completely reversed. It is said by many would-be prophets in our own country that the same situation would undoubtedly develop in the United States once a law had been enacted.

Without doubt, the medical profession in our country will be confronted with the necessity for making serious decisions. During 1948, a national election year, the two chief political parties are sufficiently diverse in their fundamental philosophies to demand contrasting attitudes on a national health program. Whether the exigencies of practical political life will tone down the contrasts demanded by opposing philosophies as applied to the national health program or whether the two parties will dare to exhibit their contrasts with emphasis, remains to be seen. But whatever eventuates, there will be no way of escaping the choice which will be placed before medicine; and the worst of it is, the choice will be complicated by the fact that a vote for one or the other of the contrasting viewpoints concerning medical practice, will imply a choice of a political party.

III.

Obviously, all of the above and much more of the same kind of thinking has a special application to the Catholic physician. His religious faith demands of him adherence to the basic principle that the rendering of medical care is a fundamental obligation, and demands of the medical man, a degree of responsibility that finds its sanction only in the Church's teaching about all professional obligations. The duties of one's state of life are extensively treated by the Catholic moralist. The giving of medical care must be regarded by the Catholic physician as his solemn responsibility, all the greater because in accepting that responsibility, the physician agrees to safeguard human welfare, human happiness, and human life, all the most treasured possessions of the human individual and of human society. Outside of his obligations towards Almighty God, the physician has no other responsibilities than those of his profession. As the field of medicine enlarges, so also does the physician's responsibility enlarge. As the functions of medicine introduce the physician more and more into the intimacies of human life, thus giving to the physician

larger opportunities for the exercise of his profession, the responsibilities of the doctor must become intensified so that ethical attitudes must become the dominant attitude of the physician towards his practice. Similarly there will be outgrowths of the most diversified and intensified kinds which will embrace ever more and more the whole range of human interests, the man's home and his business, his play and his work, his politics and his religion. All of these at some time or other become the concern of the practicing physician and thereby contribute to the ethical content of medical practice.

But in the Catholic viewpoint, ethical considerations imply more than merely questions of basic right and wrong, questions of sin. The injunction of our Blessed Savior, "Be you, therefore, perfect as also your Heavenly Father is perfect" (Mat. 5, 48), is applicable no less to the physician's professional life than it is to his personal life. Mediocrity should never satisfy a Catholic physician if he has permitted the teaching of his religion to penetrate into his practice, since according to our Faith, Christ has identified himself with the patient, "I was sick and you visited Me" (Mat. 25, 36). The service of Christ by the physician demands the application of the highest possible competence and excellence in the service of the sick. Only service of such a degree of perfection is worthy of the ideals of the physician.

Our prayer, therefore, may well be, that as medicine enters upon the year 1948, it may prove itself more and more worthy of the great vocation to which God has called the medical practitioner in bringing the results of God's omnipotence and all-loving care into the lives of human beings. Such a vocation is vast and impressively dignified. It can lead the physician in his service to humanity to the highest ethical dignity and Christian perfection, but the disregard of such a vocation may also lead the physician to the deepest human depravity. May the life of the Catholic physician ever be an exemplar of Christ's attitude towards those who appealed to Him for help in their body and mental infirmity.