



The Shame of American Medicine*

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The success of American medicine is often attributed to the profession's ability to serve the public on its own terms. Why should doctors care if, from the patient's point of view, the terms chosen—solo practice and emphasis on the “doctor-patient relationship”—mean that a doctor performs unsupervised services for unregulated fees? What does it matter to them that the poor are outside the system altogether, treated in charity wards or public hospitals which are the medical equivalent of Andrew Carnegie's libraries, a small concession to charity from an accelerating machine of wealth, power, and influence? In a country proud of its “pluralism” and fearful of “government interference,” a monolithic self-regulating profession is taken as a sign of health. Few people are persuaded that medical care is a fit object of social planning: We have no national health policy and we are mostly proud of it.

It has left us in an extremely unfortunate mess. At its best American medicine may very well be the best in the world, as its practitioners claim, which is why retired English kings and Arabian sheiks turn up regularly in our hospitals. But though excellent treatment is usually available to the very rich, the rest of the population finds even adequate services hard to come by. The charge frequently made by crit-

ics that ten countries have lower rates of infant mortality and longer life expectancies does not mean that the Peter Bent Brigham Hospital, for instance, is somewhat slipshod; it means that most people will never set foot in any place half so good.

The situation of the poor is particularly appalling. In Boston, a health survey of a public housing project indicated that among individuals over 65, 25 per cent had chronic bronchitis, 20 per cent had chronic nervous disorders, 12 per cent were blind or had visual defects, and that 40 per cent of these were not receiving treatment. In New York, former Health Commissioner George James has estimated that 13,000 poor people died last year because adequate professional care was not available. The maternal mortality rate for U. S. whites (in 1961) was 2.5 per 10,000 live births. For Mississippi Negroes, it was 15.3, more than six times as high. In a South Carolina county, every tenth Negro child died in the first year of life.

The poor are not wholly without opportunities for medical care. But the public facilities that do exist perpetuate a grotesque circle of personal humiliation and medical lunacy. In many cities a mother cannot take a well baby for a check-up to the same place she must take a sick child for diagnosis or treatment. If she suffers from both migraine headaches and pains in her chest she may have to go to two different clinics herself. Clinics (and emergency rooms) are often far away, in a sometimes unfamiliar “downtown.” For a suburban

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mother with a car and a maid such problems would be easy to surmount. For the poor mother it is different. Each clinic visit may take a separate trip. Each trip means, if she is working, a day's lost pay; or, if she customarily cares for her children, an arrangement with neighbors. It means costly taxi fares or time-consuming bus trips. After a long wait in a crowded room arranged like a bus terminal, she may be ordered to go elsewhere or to return another day. She may be asked to undress in the hallways and, thus stripped, to explain her problem to various impersonal functionaries, to what bureaucratic purpose she can hardly be expected to understand. If she sees a doctor at all (no certainty) he will not be the one she saw last time or the one she will see next time. Her medical records may be scattered about the city. She is apt to be submerged in an avalanche of prescriptions and regimens incompletely understood (for there is no one to explain them to her) and often mutually incompatible.

And so the poor, faced with a system that discourages them from seeking care, and beset with other crises that may seem to them more urgent than a nagging cough, have acquired a certain reputation among the professions: They "don't care" about their health, "don't keep appointments," "won't cooperate," "don't do what you tell them," and even "don't mind being sick." The hoariness of this mythology is clear from a recent study of English hospital development by Brian Abel-Smith. He reports that during a government inspection of English pauper hospitals in the 1860s:

At Kensington and Paddington some of the sick were "found washing in their chamber pots." The inspector was told by one medical officer that the patients preferred to wash in this way but he later established that they did this "against their will and their former habits at home." Only a few [institutions] provided lavatory

paper on the grounds that "a very large proportion of the poor" were not in the habit of using it. There were, however, "numberless instances" of closets being blocked with "old towels, dusters and dishcloths—and leaves of Holy Scripture . . . One or more Bibles, and sometimes a Prayer Book, were found in each ward, but in a more or less imperfect and dilapidated state—a circumstance connected with the subject just discussed."

Even the best of the organized health plans have sometimes had difficulty staffing their units in the ghettos: Disgust is the other face of charity.

But the medical system has not only failed the poor: It is also cheating the middle class. There is a joke popular with medical students: "What are the indications for a hysterectomy?—Two children, a Blue Cross card, and a uterus." Unfortunately, it is no joke. Every review of the quality of medical care has found a high rate of unnecessary and incompetent surgery, of faulty and delayed diagnosis, of sins not only against medical science but against common sense. A famous study by Columbia University's School of Public Health and Administrative Medicine of the medical care of a group of Teamsters and their families in New York City a few years ago concluded that one fifth of the hospital admissions were unnecessary and one fifth of the surgery was "poor." (1)

More than a third of the hysterectomies and more than half the Caesareans were held unnecessary. A study sponsored by the Rockefeller Foundation and the University of North Carolina Division of Health Affairs of North Carolina general practitioners in the 1950s found that 44 per cent were failing to take medical histories, using unsterile instruments, conducting incomplete examinations without using laboratory aids and without having patients undress or lie down, or prescribing irrelevant drugs. "The physicians studied came from

many medical schools and had exhibited all degrees of academic success," the report stated, "so there is no reason to assume an adverse selection. It can . . . be stated with considerable assurance that in terms of medical education and training the physicians who participated in this study are not evidently different from general practitioners at large." (2)

Ethical controls are as lax as the medical ones. Denunciations of fee-splitting issue periodically from the professional associations. But doctors combine to buy pharmacies in medical buildings; take payments for journal articles they have not written endorsing drugs they have not tested; conduct medical and surgical experiments on their patients without telling them; cheat on insurance; and, like the GE executive who went to jail, they retain an honored place among their colleagues and within their communities. (3)

Middle-class medicine is facing a crisis in costs as well as quality. Hospital rates now average over \$40 per day and insurance rates have taken off like a rocket. To a certain extent this is the price of technological achievement: A heart-lung machine, for instance, and a cobalt machine for treating cancer may cost in the vicinity of \$100,000 each, and each requires a small army of skilled technicians for its upkeep. It also reflects the inroads of unionization on hospital pay scales. Salaries have been so low that in New York, for example, some hospital employees were recently receiving public welfare while holding down full-time jobs. But to a large extent the doctors themselves are responsible for the inflation: An electrocardiograph standing idle for thirty-five hours a week in the private office of a Park Avenue internist is an exceedingly costly instrument, and the costs are reflected in his bills. The inflationary pattern of solo practice is reinforced by the pattern of insurance plans. Nearly 150 million Americans have some,

but it covers on the average only 30 per cent of a family's regular medical bills. Hospitalization insurance is easy enough to obtain, but it is hard to buy policies that cover office or home visits, drugs, outpatient diagnostic tests, or psychiatric or nursing care. The payment system common to insurance—so much for a hernia, so much for a tonsillectomy—supports the ideology of solo practice in another way. It encourages both doctors and patients to think of health negatively, as a series of episodic battles against discrete afflictions. In this system the concept of "comprehensive" or preventive care has little place.

The result is poor medicine and poor policy. It is poor policy because it leaves both doctors and patients dependent on hospitalization—the patient, in order to pay his bills, the doctor to collect his fees—and obstructs development of more rational and humane outpatient, home, and nursing services that could be more cheaply arranged. The present dilemma of the hospitals—shortages of services in some areas and underutilization in others—has additional causes: administrative rigidity, regional competition, desultory Federal supervision, and technological leapfrogging that has left many small institutions unable to perform modern services adequately. But hospital-oriented insurance has played a major role not only in overcrowding many hospitals but in deflecting attention from their defects. In addition, the system leads to poor medicine because it subsidizes the costs of catastrophe, not the preventive care that might minimize catastrophe, and it is flourishing at a time when medical victories over many acute diseases and the growing proportion of old people have made arrangements for preventive and long-term care all the more essential. Illness is simply more flexible than insurance. As Anne Somers pointed out in a recent paper:

The corollary of this shift [to an

aging population] is increasing need for long-term preventive, rehabilitative, semi-custodial, and medical social services. Most chronic diseases are months or years in developing and require early diagnosis if they are to be handled effectively. The period of treatment is, by definition, extensive. If "cure" is achieved, there is often required a long "post-cure" rehabilitation. Generally, the most optimistic solution is stabilization—for example, in diabetes or glaucoma—under continuous life-time medical supervision. With such changes in morbidity and disability patterns, the distinction between health and illness becomes blurred, and the concept of medical need increasingly difficult to pinpoint in space or time. Rather there is a continuous spectrum with varying degrees of emphasis. It begins before we are actually ill; it does not cease when we are discharged from the hospital. Continuity and comprehensiveness have become indispensable aspects of effective medical care. (4)

The failure of health insurance to deal with this situation is not just a coincidence. As the Somerses' study makes clear, Blue Cross and Blue Shield originated in doctors' efforts to protect their incomes. (5) Blue Shield plans are dominated by local medical societies; Blue Cross plans by hospital representatives. In neither is there much effective public representation. The commercial plans have broken little new ground. In theory, health insurance might have been developed by independent groups who preserved some power to supervise the hospitals and private practice: There is growing pressure for such supervision now from regulatory bodies (state insurance commissions) and organized consumers (business and unions). They have begun to feel that their soaring payments for member or employee health plans cannot be justified without questioning both the cost and the quality of the treatment they are buying. But until now the system has been manipulated by the doctors to pre-

vent outside control. The doctors opposed medicare because they feared that their freedom from review would come to an end under a system of government insurance, and that rising costs would ultimately force the government to institute controls. Medicare is a conservative step, however, whatever the doctors think; for relieving the pressure of the aged (who are bad risks) on the voluntary insurance system will temporarily conceal some of the cracks the system contains. We continue to revolve in a circle of high costs and high rates that leaves millions of people unable to afford insurance at all, and those who have it stuck with unsatisfactory policies which hardly begin to pay their bills. The result has called forth the invention of a new category of social dependency known as "medical indigence": According to a recent study, 80 per cent of the patients in New York's municipal hospitals were people who are not on relief and who normally "manage to cover their ordinary expenses but lack the margin in income, savings, or health insurance to pay the hospital and the doctor when they get sick." (6) If the doctors continue to have their way, they are likely to make medical indigents of us all.

What is to be done? For about thirty years, the "progressive" elements in American medicine—and there are some—have been formulating plans for the reorganization of medical care. These reformers are not an organized group but individuals associated chiefly with medical schools and public health programs who have come together, over the years, in foundation-sponsored and government-sponsored committees and study groups to consider the organization of medicine. (7) Their prescription has three interrelated ingredients. First, they believe that solo practice should be replaced by teams of specialists mobilized into "group practice," thus both enlarging the intellectual and technological resources

of the doctors, and lowering costs. Second, they propose that inclusive prepayment plans (providing, among other things, regular salaries for doctors) should replace traditional fee-for-service compensation. Third, they urge that hospital services should be expanded and more efficiently organized both regionally (to avoid the inequitable and inefficient maldistribution of expensive, specialized equipment) and within the hospitals themselves (to offer patients a range of flexible services correlated with their needs as these change during hospitalization). There is no reason why the patient who is getting better should be imprisoned in a reign of nursing terror when he could be helping to take care of himself. Increasingly, a fourth design has been prominent: the 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; facilities would be carefully reorganized to avoid overlapping and to make a complete range of services easily available in each part of the city.

Some remarkable evidence from a few pilot projects makes plain that medical and economic logic are on the side of these reforms. The Health Insurance plan of Greater New York (HIP), for example, the largest group practice in the U. S., enrolls about 700,000 New Yorkers, many of them city employees. They are served by one of thirty-one medical groups located throughout the city, which include both a “family physician” (a G. P.) and a variety of specialists. For \$4.50 a month a person can obtain all regular outpatient medical services from eye check-ups to physiotherapy. Hospitalization costs are not included (subscribers are encouraged to join Blue Cross) although full surgical costs are. Physical examinations and other preventive services are offered

without cost and without limit. The availability of outpatient care seems to promote both health and economy. Studies have consistently demonstrated that the rate of hospitalization and the length of hospital stays of HIP patients are substantially lower than for patients treated and insured by conventional means. (8) More striking, the health record is better. The prenatal death rate among HIP subscribers, for instance, is lower than among patients seeing private doctors. (The lower rate holds among comparable groups of whites and non-whites; among families with comparable incomes; and among families where the wage-earners have comparable occupations.) HIP subscribers suffer fewer infant deaths in the first week after delivery; the average weight of infants at birth is higher; the prematurity rate is lower. The record of other group health plans is the same.

In a limited way, it is true, some “reform” has already begun. The influence of the medical schools and hospitals is rising and solo practice is, statistically, on the decline. Nonetheless, the number of people being served by the new arrangements is small. Lying between successful demonstrations of progressive ideas and their wide application are two things. The first is the unrelenting obstructionism of organized medicine. In 1943 the Group Health Association of Washington, D. C. successfully brought an anti-trust suit against the AMA and the local medical society for conspiring to restrain trade. But elsewhere, from then till now, physicians entering organized groups have found themselves subject to harassments ranging from social ostracism to suspension of medical society privileges. Twenty-three states still have laws prohibiting group practice except in a form approved by the medical societies. In only about a dozen cities is it even possible to enroll in a full-fledged group practice program. In the same way, the profession has bitterly resisted the

trend toward including specialists' services as part of hospitalization, insisting that the radiologist who takes X-rays or the anesthesiologist who gives the injection are private, personal physicians, equally entitled to that “special relationship” with their patients that permits them to send a bill. (9) Their fear arises from a domino theory of medicine: As radiologists go, so will go the obstetricians, gynecologists, and internists. Group practice will have a beachhead in the hospitals and fee-for-service practice will come to a stop. The Communists will be at Waikiki.

Supporting the intransigence of the profession in the face of change has been the weak and neutral policies of the federal government. We spend billions of dollars on medical research (paying particular attention to the pet afflictions of the aging politicians who appropriate the money) and billions more on hospital and other construction programs. These have succeeded chiefly in proliferating the interests opposed to change. But aside from providing direct medical care to specialized portions of the population (mainly federal dependents), the government has left what is known in the trade as “the delivery of medical care” alone. There is one exception, the Heart Disease, Cancer, and Stroke legislation passed in the last session of Congress. Following the “progressive” model, this calls for regional cooperation among existing health agencies to advance the research, diagnosis, and treatment of the three diseases. But like the Medicare bill which promises that no Federal official shall be permitted “to exercise any supervision or control over the practice of medicine or the manner in which the services are provided,” the Heart, Cancer, and Stroke Bill promises to accomplish its ends “without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals.”

Medicare itself may ultimately be responsible for overturning that intention. Experts anticipate that the availability of payment after July 1 will lead to a sudden, crushing demand for medical services that the present disorganized system will be unable to supply. If they turn out to be right, medical care could become a major political issue, and pressure from angry consumers could force the government to play a stronger role. But that is not the way it was planned. When federal officials go up to Capitol Hill to testify that the programs they are endorsing will "save us from socialism," the trouble is that they mean it. They are committed to a timid reformism that masks their unwillingness to retrieve power from the very institutions which need to be reformed.

The idea that the government would take the lead in ending the chaos in medical care was subtly undermined last summer. The AMA convention in New York last June was perhaps the lowest point in the profession's recent history. There were hysterical discussions of medicare ("we would be zombies stepping into involuntary servitude if we accept such fascist control") and intense debate about a doctor's strike ("... it is ethical, proper, desirable, moral and legal not to participate in such socialistic schemes"). Peripheral groups of doctors, formed out of concern with racial discrimination, or with foreign policy, or with the economics of medicine, were beginning to talk seriously about founding a rival association. In Washington, the influence of two potential competitors to the AMA—the American Hospital Association and the Association of American Medical Colleges—became increasingly apparent. An influential coalition of physicians centered around philanthropist Mary Lasker had been moving away from its initial preoccupation with medical research and into questions of medical care. The AMA was in a shaky position and its leaders knew

it. After the confusion of the convention, they went to Washington, timorously, to say that they would, after all, cooperate in drawing up the regulations to implement medicare. And the government—in effect, the chief officials of the Department of Health, Education, and Welfare—took them back. They supplied the doctors with new prestige—a visit with President Johnson—and took some advice on medicare rules and the Heart, Cancer, and Stroke Bill. The new guard at the department might have demanded positive evidence of a change in attitude and definite commitments for AMA support of creative legislation. Instead they lost themselves in public celebration of a fuzzy and undependable "partnership." This same concept of "partnership"—solicitude for established interests—is also rapidly obliterating hope of rapid progress in critical areas of environmental health. We pass a bill requiring a mild cigarette-label warning, but prohibit any other warnings on packs or ads till mid-1969. We pass a strong water pollution bill but leave intact a Jeffersonian formula for distributing grants that actually discriminates against the crowded urban areas where pollution is most serious. We permit the poverty program to offer birth control but refuse to let it instruct the unwed mothers who need contraceptives most. We support research on traffic accidents but permit researchers to withhold the names of auto manufacturers with the most treacherous designs. To celebrate partnership is, usually, to celebrate a deal.

In the case of medical care, there has been a deal, and all of us are the objects of it. The system, in which the government has acquiesced, is designed to keep the doctors well-nourished and the middle class quiet. Discontent over the organization of care is diverted into humble appreciation of scientific triumphs. Doubts about the treatment of the poor are smothered by periodic stories of dramatic recov-

eries on the wards and by the Robin Hood notion that "our" prices are high because the doctors are working charitably for "them." From the system that offers both a cure for our tuberculosis and a salve for our conscience, we will suffer both humiliation and extortion. The middle class does receive better care and consequently has a better chance for survival than the poor have, but in a subtler sense it is equally victimized. The agility of middle-class patients increases their ability to navigate in the system, obtaining supporting diagnoses or shopping around for more compatible, or lower priced, or more fancily equipped, doctors. But none of us can really change the attitudes we encounter, modify the orders we are given, avoid the charges we are told to pay, or look to anything outside the closed shop for comfort or support. It was precisely this condition of dependence that weakened the wariness some government officials harbored secretly during their reconciliation with the AMA last summer: The officials knew that, from a practical point of view, the AMA represents the only doctors we have. The exceptions, the clusters of independents and critics, are too few numerically and too concentrated geographically (in urban centers) to be the base of a reorganized system of medical care.

Nor would the subtler defects of the system be fundamentally affected if there were more renegades. We would be at the mercy of the good guys instead of the bad guys, but the good guys share with the bad an instinctive commitment to the idea of total professional control. There are some exceptions. The Tufts Medical School has set up a health center in a desolate housing project on the edge of Boston that in effect combines group practice with public control. The formula is the standard requirement of the Office of Economic Opportunity—a board composed of members of the local community. But it is working out with the seeming

difference that, unlike most mayors, the Tufts doctors enjoy working with the residents in a non-authoritarian fashion and are actually committed to the idea of "community participation" in the process of medical care. No welfare mother is about to start taking throat cultures, but the doctors are trying to share power with the community in a number of nonspecialized areas of policy: The residents influenced the design and furnishing of the health center facility for example; more important, they helped to define the conditions of service (including clinic hours, payment, and so forth) and will help in their execution. Tufts also plans to train Columbia Point residents for a range of sub-professional jobs at the medical center, something that may help to reduce the psychological gulf between doctors and patients. The school is planning a similar project in the rural South. In a few other cities, elements of the scheme—the training of the poor as health assistants or the development of neighborhood health centers—are being talked about and tried. But these projects are confined to the poor and far too restricted to be called a trend. For the most part there is reason to believe that as the progressive vision is implemented, the incapacity of the public to exercise control over the medical profession will be not lessened but exaggerated. In the Heart, Cancer, Stroke program, for example, power will reside in Olympian regional coalitions resting on medical schools, hospitals, and public and private health agencies; in New York's controversial "Trussel Plan" the city has in effect turned over the administration and control of municipal hospitals to the private hospitals and medical schools. (10) The progressive vision in medicine is a corporate one, a response to institutional inefficiency and waste, not to personal inhumanity and confusion. But that, in all probability, is where we are heading. If they oil us now and then, and shore up our out-

worn parts, will we ask for anything more?

1. Selig Greenberg, *The Troubled Calling: Crisis in the Medical Establishment*, Macmillan, 1965, pp. 208-210.
2. Herman M. Somers and Anne R. Somers, *Doctors, Patients, & Health Insurance*, pp. 31-32, notes 7, 8 (Brookings, 1961) and Selig Greenberg, "The Decline of the Healing Art" in *The Crisis in American Medicine*, Harpers, 1961, p. 22.
3. Documentation of links between physicians and pharmaceutical operations can be found in last year's hearings of the Senate Anti-Trust Committee on "Doctor-Owned Pharmacies" and in hearings of the House Government Operations Committee on "Drug Safety." *Science*, Feb. 11, 1966, p. 663, and *The Saturday Review*, Feb. 5, 1966, p. 61, discuss human experimentation. Doctors' abuse of insurance is reported in Greenberg, *The Troubled Calling*, p. 207 ff.
4. Anne R. Somers, "Some Basic Determinants of Medical Care and Health Policy: Trends and Issues." Paper prepared for Seminar on Health Policy, Institute for Policy Studies, Washington; January 25, 1966.
5. Somers and Somers *op. cit.*, chapters 15 and 16.
6. Nora K. Piore, "Metropolitan Medical Economics," in *Scientific American*, January, 1965, p. 19.
7. George Baehr, "Medical Care—Old Goals and New Horizons," 1965, Michael M. Davis Lecture, The University of Chicago, May 13, 1965. Among the most important groups was the Committee on the Costs of Medical Care, established with philanthropic support in 1928. Another major study was produced by the Presidentially appointed Commission on the Health Needs of the Nation in 1949.
8. Somers and Somers, *op. cit.*, p. 177.
9. *Science*, July 9, 1965, p. 164.
10. Robb K. Burlage, "Issues of a Changing Hospital System, with New York Case Study." Preliminary study, Institute for Policy Studies, Washington, 1965.

Notes on Bibliography:

By far the most valuable book on the

organization and financing of medical care is the volume by Herman M. Somers and Anne R. Somers, *Doctors, Patients, & Health Insurance*, Brookings, 1961. The Somerses drew freely on disciplines of political science, economics, and public administration in analyzing factors affecting medical care, and they succeeded in producing a study both lucid and comprehensive. Selig Greenberg's *The Troubled Calling: Crisis in the Medical Establishment*, Macmillan, 1965, \$6.95, is essentially a journalistic popularization of the same issues treated by the Somerses, but it tends to be repetitive and not always to the point. A more original popular inquiry is *The American Health Scandal* by Roul Tunley, Harper & Row, 1966, \$4.95. In addition to an unpretentious and readable chronicle of the organization of medicine in the US, Tunley provides a helpful survey of how England, Sweden, Yugoslavia, Germany, and Canada organize their health services. *Hospitals, Doctors, and the Public Interest*, John Knowles, ed. (Harvard University Press, 1965, \$8.50) is a collection of essays by experts, some of whom approach their subjects from a perspective somewhat obscure to a general reader. The politics of the drug industry are closely examined in Morton Mintz's *Therapeutic Nightmare*. Finally in a class by itself, is *The Hospitals in England and Wales, 1800-1948* by Brian Abel-Smith, Harvard University Press, 1964. It succeeds not only in illuminating unexplored corners of British social history but in documenting how English and American medicine grew to be so different.