The Linacre Quarterly

Volume 3 | Number 2 Article 2

March 1935

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who get a great deal of science, or sometimes supposed science into them, often have no room for faith in conjunction with the science. It is these men who are the disbelievers in religion. They blame it on their science, but the real reason is the size of their minds.

"I suppose that practically everyone with a right to an opinion in this matter would agree that the most distinguished member of the medical profession in this country today is Dr. William J. Mayo of Rochester, Minn. He has recently put himself on record with regard to this question of medical science and faith. He said, as reported in the *New York State Journal of Medicine*, November 1, 1934: 'There is a tendency of the time for a group of intellectuals, that is, persons who have been educated beyond their intelligence, to underrate the value of religion as the universal comforter in times of physical or spiritual stress, but to the mass of the people religion has the same potency that it has had for two thousand years. The sick man needs faith, faith in his physician, but there comes a time when faith in a higher power is necessary to maintain his morale and sustain his emotion. I do not know how the doctor can strengthen that faith, unless he himself knows and practices the values of religion, not necessarily the creeds and dogmas of any particular church.' It is easy to understand that last sentence when it is realized that there are altogether some five hundred sects in this country, separated from one another by divisive dogmatic creeds, each of them the invention of some man during the past three or four hundred years whose name, as a rule, has become attached to them."

SOCIALIZATION OF MEDICINE

By REVEREND WALTER G. SUMMERS, S.J.

The writer of this keen analysis of causes and conditions tending towards the socialization of medicine was formerly Regent of the Georgetown University Medical School and is at present Head of the Department of Psychology, Graduate School, Fordham University. The present paper was delivered at meetings of the Manhattan and Bronx Guilds and is printed as the result of many requests.—EDITOR.

THE efforts of organized medicine to care for the indigent sick form one of the most stimulating and at the same time one of the saddest chapters in the annals of medicine. The original purpose of the Hotel Dieu was to provide medical service for those unable to finance private medical treatment. This tradition of service has been carried to our present generation by the example of all great hospitals and has been manifested in the devotion to the sick outside of hospitals by doctors throughout the world. Due to the effects of our economic situation, the attention of the public and of the medical profession has been focused on the practice of medicine especially as it applies to people in the indigent and middle classes.

Changes in industrial conditions have produced a large body of unemployed whose poverty is created by the inability of society under

present legislation to furnish opportunities for work. Neither hospitals nor doctors could reasonably be expected without financial recompense to provide adequate medical care for this gradually increasing number of people who had no means to pay for medical assistance. This situation resulted in the control of the relief measures, first by local governments, then by the individual states and finally by the federal government. At the time when the individual states began the assumption of the duties concerned with relief activities, there arose a new group who attempted to earn a living at charitable work. Although individuals of this type had operated more or less independently before the beginning of state control, the organization of social workers and the diversification of organized social activity on a large scale date their origin from this period. What was termed "charitable" work now becomes "social" work, social welfare, public welfare, public health. The census of 1930 shows that this new "profession" has 31,240 members; and that over 50,000 more people are similarly employed as keepers of charitable and penal institutions, religious workers, probation and truant officers.

The economic phase of relief tended to dominate medical care. This is not only evident in the operation of the federal plan (which came to be known as Rules and Regulations Number 7) but it began farther back in the mental attitude openly manifested by social workers that medical service by hospitals and physicians should be distributed by the social worker and not by the hospital or physician. Flushed with early successes through legislation in theory often good, but in execution frequently ridiculous when not disastrous, social organizations reached out for the control of medical service and medical practice. We may trace to this origin the medical activities of several foundations, such as the Millbank Fund, The Rosenwald Foundation, The Pollock Foundation whose spokesmen in medical matters have advocated the socialization of medicine and have endeavored to secure state and federal legislation to this purpose.

Hospitals were affected by advances in medicine and by economic changes. The number and the status of hospitals had changed. Originally organized to care for the sick poor and conducted most frequently by people who had devoted their lives to the care of the poor and the sick without thought of monetary return, they now become very costly institutions in construction and in equipment whose services are sought by increasingly large numbers of pay patients. The amount of capital required for the construction and maintenance of first class hotel facilities for large numbers of pay patients gave rise to the corporation idea in many of these institutions. Practically all such hospitals [1] retained or organized charitable activities. Facilities for out-patient departments and clinics multiplied in scope and activity

between fifteen and twenty times during the present century. This increase of facilities and activities involved the acceptance on a charity basis of a large number of people who would normally be considered above the clinical level. But all through this change in activity, the medical care was most generally donated by the physician or exacted from him as a condition of staff affiliation.

The growth of the public health movement has likewise seriously affected medical practice. Organized medicine began and fostered the activities of public health centres. But the public health movement turned out to be a thankless usurper and organized medicine, unable to control the growth of this obstinate progeny, ultimately objected to its widespread operations for the reason that public health procedure disrupted the personal relationship between patient and doctor, the relationship which organized medicine held necessary in the treatment of human disease. To these agencies which made inroads on private medical practice we must add the system of contract medical practice by lodges, business organizations, fraternities, insurance ventures, etc., all of which tended to offer medical treatment at bargain rates. All these factors are cumulatively improverishing the medical profession. And on the other page of the ledger is the amount of service freely donated by physicians which, if estimated in money, would be greater than all the public and private cash donations for indigent relief in any given year with the possible exception of the years which have succeeded 1932.

Since 1929 all these tendencies have been focused. The system of hiring physicians for the indigent sick has broken down due to the additional number which required treatment. Many corporation hospitals are in the hands of receivers. They found their pay patients diminishing and their charity patients increasing. They began to market their wares at lower figures. And those who held mortgage and other financial interests in such hospitals looked desperately for any means to safeguard their investments. The managers and directors of some hospitals which had large clinical facilities ruined the private practice of medicine within extensive radii of their institutions through their failure to set up any standard for admission to the clinics other than the clinic fee. Many counties began experiments in the donated services of physicians. These county organizations set up methods routing patients in need of medical service for which they could pay little or nothing. In all these experiments practically every county organization insisted on this: that basic medical service is best rendered the community when the physician functions as a private practitioner.

By 1932 the existing system for the relief of the indigent sick was breaking down in nearly every state. To meet this situation the

federal government instituted a plan which is now termed Rules and Regulations Number 7. The important feature of this plan is to be found in the fact that the control even of medical relief is determined by a Relief Administrator in each state. No doctors were included in the advisory committee, the original committee assembled for the discussion of a federal plan for relief. It is likewise noteworthy that Falk and Sydenstricker were members of this committee. The control and responsibility for the character and extent of medical service were taken from the physician and put in the hands of an economist or social worker or unqualified political appointee.

For many of these consequences the medical profession has itself to blame. There are too many doctors. "According to the report of the Commission on Medical Education, the United States has more physicians per unit of population than any other country in the world, and twice as many as the leading countries of Europe. With a total of 156,440 licensed physicians in the United States at the present time, there is one for every 780 persons. England has one doctor for 1,490 persons, France has one for 1,690, and Sweden has one for 2,890.

"It is estimated that a reasonably complete medical care can be provided in this country on the basis of one physician to about 1,200 persons; that an adequate medical service for the United States could probably be provided by about 120,000 active physicians. According to these figures there is at present a surplus of approximately 35,000 physicians.

"If the present rate of supply is continued, the number of physicians in excess of indicated needs will increase. By actuarial calculations it is estimated that by 1940 there will be in round numbers 171,700 physicians, and in 1980 about 211,800. The number of persons per physician in 1940 will be 760, in 1960 about 730, and in 1980 about 690."

"It requires no special actuarial philosophy to forecast what such a state will mean to the economic welfare of the future practitioner.[2]"

Much of the present unrest and commotion about state and socialized medicine is traceable to economic uncertainty which in turn derives in great part from the social dangers which have developed as the result of an over-crowded and ill-distributed supply of doctors. In New York City there are at present 13,085 doctors. The ratio here is approximately one doctor for every 500 population which compares very unfavorably to the ratio of one to every 1200 mentioned by Bierring.

Medical School training in this country is generally over-specialized. When we add to this fact the high cost of medical education and the additional circumstance that the average young doctor does

not begin private practice until he is in his latest twenties, it is easy to appreciate the desire of so many young doctors for the practice of those medical specialities which will insure the quickest and largest financial return. The medical profession insists through its spokesmen and journals that the personal and fiduciary relationship between patient and doctor is a necessary rapport for the effective and proper administration of medicine. Yet the general run of training in medical schools tends to destroy the necessity of such relationship in the mind of the medical student. He is made too dependent upon laboratory assistance. The average doctor will earn his livelihood by the treatment of ordinary disease. In the older systems of teaching medicine, the student was taught to use his hands, his ears and his eyes to a degree not manifested in the effects of modern teaching. The selection of professors in medical colleges as in other colleges of this country is frequently based upon an erroneous principle. Doctors are "called" to medical school staffs and professors are invited to collegiate staffs very frequently because of the papers they have printed or the books they have published. Such work may be a manifestation of the creative ability required in research and graduate departments. But the main function of a teacher in a medical school or for a professor in a college is to impart and explain to his students what is already known. This ability for the clear exposition of undergraduate material is seldom investigated and frequently lacking in medical school professors. Specialization has its proper field in the complicated diseases or in other aspects of medicine which we might classify as the graduate plane of medicine or surgery. But the objective of undergraduate medical education should be the training of doctors for general practice and not for specialization in every field of medicine included in the medical school curriculum. The field of specialization offers an additional difficulty for the patient. Several medical and surgical organizations have initiated the very praiseworthy procedure of segregating the sheep from the goats in the matter of specialized medical practice. But they have not gone far enough. There should be some segregation of a type by which a patient might know when he is visiting or being treated by a specialist and not by a pretender.

The practice of medicine requires a social background and a cultural level of a degree and type second only to the practice of the Sacred Ministry. The personal sacrifices of the great men in medicine have been inspired by an ideal of service. There have been many great medical men who had no religion. But they usually made a religion of service to the sick. The oath of Hippocrates for the real doctor is not a piece of idle rhetoric. For as he goes on in years he becomes convinced that the practice of medicine without that or some similar ideal of service, becomes a business, purely a matter

of salesmanship. The particular ambition of some who enter the practice of medicine is the attainment of power and social prestige. We do not propose to discuss here the principle of "sane selfishness" as contrasted with the spirit of Christian love and sacrifice, but this spirit of "sane selfishness" is very frequently synonymous with an absence of moral standard. Medicine for such people is a business with *Caveat Emptor* written in very small letters in a dark corner of the entrance. A man or woman who enters the practice of medicine primarily for business purposes is bound to be a traitor to the noblest ideals and traditions of that profession.

It is not surprising that the metropolitan area should see and hear many evidences of this effort to secure socialized medicine. The devastating influence of medical centres and clinics will result in insufficient remunerative work for the private practitioner. Unethical practices to secure patients will be prevalent. The inroads made by younger and commercially-minded doctors on the practice of the older will make this particularly felt. It is to be expected that literally hundreds of doctors should move from the metropolitan area because they refuse to sacrifice their standards, their ideals of honesty and fidelity to a younger generation who openly scorn the oaths they have taken to support good practice and honest dealing among the members of their profession. It is to be expected, too, that there should be a hue and cry from the disillusioned, the inept and from those whose business expectations have not been realized, a demand for a wage of any sort, from any place, as long as they can write an M.D. after their names. In other lines of endeavor, architecture, law, engineering, there is no cry for state control or socialization. But there are many doctors, lazy, inefficient, inept, convinced that the world owes them not only a living but a large measure of deference and financial security, in some way due them above all other workers in the vineyard. The impracticability of socialization is very obvious from a financial viewpoint.

Socialization would not only include medical treatment and care, but would include surgical operations and surgical treatment. It must further take into account all forms of medical or physical health activities recognized by the state, such as osteopathy, chiropractic, etc. The cost of medical care on a socialized plane would necessitate an outlay for nurses, for training schools for nurses, for medical and dental schools, for the maintenance and conduct of training schools, of medical schools, for hospitals—for medication, laboratory technicians, for various types of assistants. It is a simple matter to see that the cost of such socialization would involve a sum greater than the total budget of New York State for any one of these depression years.

Doctors are greatly responsible for the public attitude towards their profession and for the fertile field on which the propagandists of state and socialized medicine are sowing. By their association with clinics, cheap service and out-patient departments, they cultivate the attitude that medical attention should be free. We have already stated that this attitude, while not primarily initiated by doctors, is fostered by hospitals which donate the services of their medical staffs. With their disregard of the eligibility of patients for clinical service, they have seriously interfered with legitimate private medical practice. And because of their cheap medical service and volume of business they can succeed where the private practitioner is bound to fail. Doctors are likewise responsible for the difficulty which exists whereby the very poor and the very rich can obtain the best medical service; and whereby people of the middle class are left without adequate medical attention. We do not believe that doctors, surgeons, can remove all ills or that they hold the secret to perpetual life. Nor do we believe that any system of legislation will effect perfect health or perfect eugenics. But these are the goals of many agencies who are striving to bring about legislation which will ultimately remove medical care and attention from the doctor and put it in the hands of a welfare agency and the principal arguments for their proposals are based upon the failure of organized medicine to eliminate the quacks from its own group and the inability or unwillingness of doctors to proportion their costs to the financial ability of the middle class which forms the greatest number of our population.

One hears throughout the country a frequent statement to the effect that socialized medicine in some form is inevitable. Why should this be so? Is it because doctors are recognized to be the worst people in the world for co-operation? Is it because the deference shown by subjects leads generally to an exaggerated *ego* which scorns advice and criticism? Is it because doctors feel that somehow the grand dignity of their status will not be affected by the activities of less intelligent, less highly endowed, more political organizations? The admission that socialized medicine in some form is inevitable is an admission of defeat. It is an admission of a willingness to hand over a royal heritage for the dubious privilege of standing in a socialistic bread-line. It is an admission of an unwillingness to face and to correct what needs correction in the present practice of medicine. It is an admission of an inability or unwillingness to do anything constructive through fear of political disfavor or loss of apparent prestige. It is the admission of treason to a great trust: that the financial security of him who has vowed his life to the care of the sick is held more sacred than the real security of patients and doctors in medical practice. It is an admission that organized medicine is a shibboleth,

a name; that medicine is not organized if it cannot clean its own house as it knows this must be done; that the American Medical Association, the American College of Surgeons, the American College of Physicians, etc., etc., are welcome visitors to the hospitals of the land provided they do not interfere with the commercial policy of these hospitals. The individual doctors or small groups of doctors are powerless to effect an ultimately satisfactory solution to this problem. But they can and must discover by practical methods how organized medicine can organize to weed out the unfit from its ranks. They must organize to gain the necessary sanction to protect patients from unscrupulous doctors and physicians and surgeons and hospitals. They must organize to arrange for the adequate treatment of the great middle class for reasonable fees. And finally they must organize to keep out meddlers, with which this country has been cursed from its earliest days. Call them organized minorities, if you will, but the significant fact is that they *are* organized. And in the organizations which are agitating the cause of socialized medicine there are many business people, adroit, far-seeing, planning long range plans for the future. The entire threat of socialized or state medicine is made possible by a sense of false security in hospital directors and in doctors themselves. If socialized medicine should ever become a reality, doctors must blame themselves if they are forced to view the ruins of a great edifice with the mumbled explanation: We were not prepared.

[1] *American Medical Association Bulletin*, October, 1934, p. 136, ff.

[2] *The Family Doctor and the Changing Order*, Walter L. Bierring, *Journ. Am. Med. Ass'n*, June 16, 1934, p. 1997, ff.

GUILD NOTES

AN ANCIENT MEDICAL GUILD

The organization in recent years of Catholic Medical Guilds in England, Ireland, and our own country, has created interest in similar institutions of former times. The first issue for 1935 of the *Catholic Medical Guardian*, London, in keeping with its tendency, presents to its readers what is known of the ancient Medical Confraternity of San Pantaleon of Granada, in Spain, based to an extent on information contained in *Philos*, the organ of the Federation of Spanish Medical Guilds.

We know that in 1488, the Guild of SS. Cosmas and Damian of the ancient city of Zaragoza (Saragossa) received from Ferdinand, the Catholic, a charter which allowed its members the altogether exceptional privilege—at that time—of dissecting the human body. This was half a century before the period of Vesalius and when even the famous University of Salamanca was allowed no such favor.

But then there were other guilds of a similar type in Spain, and it is not unlikely that amongst them was the Cofradia de San Pantaleon of Granada which has recently joined the Federation of Spanish Medical Guilds.

In the Roman Martyrology we read that "At Nicomedia, the passion of St.