

The Only Solution I Can See is to Return Health Care Decisions to Informed Consumers and Cost-Conscious Physicians

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J. Donald Hare was born in Caledonia, NY, and attended Harvard College as an undergraduate. Following graduation from medical school, his internship and medical residency were done on the II and IV (Harvard) Medical Services at the Boston City Hospital. After two years of research experience at the National Institutes of Health, he joined the faculty of the Departments of Medicine and Microbiology at the University of Rochester School of Medicine and Dentistry and Strong Memorial Hospital, where he was an Associate Professor of Medicine and Professor of Microbiology, involved in clinical infectious diseases and cancer virology. He was also Associate Dean for Admissions at the Medical School. Following retirement in 1988, he joined the National Ski Patrol, in which he was active until 1998. Recent years have been spent in retirement in Rochester in the winter and at Martha's Vineyard in the summer.

In retrospect, my career in medicine, with its beginnings as the son of a general practitioner who graduated from the University of Toronto in 1925-1926, has essentially paralleled the transition of medicine from the era when a physician trained as an apprentice to the current education in high-tech medicine.

My father was probably in one of the early med school classes in which the curriculum was a combination of art and science. He was an excellent diagnostician who delivered babies, sutured wounds with the skill of a plastic surgeon, set fractures, held hands and was a cheerleader for the people of Caledonia during the Depression. He accepted foodstuffs in lieu of money for medical care and never demanded payment in advance. As a solo practitioner, he worked seven days a week, with office hours afternoons and evenings except Thursday and Sunday. Mornings were devoted to house or hospital calls.

Since the bulk of his early professional life was spent during the hard times from 1928, the year I was born, through the Depression and the World War II years, he usually wrote off thousands of dollars of debt each year, or he would accept small payments on a regular schedule.

He and the other general practitioners in Livingston County were quite similar in many ways. They were fiercely independent people who thoroughly enjoyed people, worked hard and enjoyed life, in spite of the very confining and demanding profession they had chosen. They could not have practiced in a group in which they would share responsibilities.

Growing up, I recognized the special requirements demanded of one in medicine and I wasn't interested. My high school years were during the darkest days of WWII/1942-46. My interest in math and science as well as the inevitable orientation toward the war and our survival as a free world directed my interests to engineering and the Naval Academy. I was accepted and matriculated at the Academy in the summer of 1946 but my naval career was cut short when my vision began to decline and I elected to resign my position rather than become an officer in the Supply Corps.

Since I had broadened my interests in my senior year in high school to include the emerging biomedical sciences, I also applied to Harvard College. If I couldn't become captain of a naval warship, then I would go into medicine, but definitely not as a GP!

As a Harvard pre-med I was first exposed to the fascinating world of biology, chemistry and biochemistry. This was the start of my interest in the science of life. I thoroughly enjoyed laboratory sciences. The broader aspects of my education were not neglected at Harvard. I enjoyed political science, psychology, English literature and drama, in particular.

Application to medical schools was pretty routine. All my pre-med classmates applied to Harvard Med but only about half were accepted. I was also interested in Columbia and Cornell as well as Rochester. One summer I worked in the research lab of Dr. G.B. Mider at the U of R. There I met Dr. Leonard Fenninger, a very bright and critical individual whose high expectations were tough to achieve. Nevertheless, the first introduction to laboratory medicine was stimulating.

I chose to attend the U of R School of Medicine and Dentistry because of the feeling of intimacy and the small town atmosphere compared to the schools in Manhattan. My interview with Dean George H. Whipple was especially interesting. We spoke about fly fishing, since I had grown up in proximity to Oatka Creek and Spring Brook, two premier trout streams, and I had learned to cast a fly as a pre-teen.

My career in medicine was settled in my second year when our class took Medical Bacteriology and Immunology. I enjoyed the subject matter and was encouraged by Professor Herbert Morgan to take a year's fellowship in his lab, in spite of the fact that we had several disputes. It was during the second year that I met Nancy Whitcraft, a lovely person, who was Head Nurse on Ward X-3, a Women's Medical Ward. It was love at first sight. We were married in the fall of my fellowship year. Nancy became an ad hoc member of the clinical faculty for our friends who continued into their third year.

With training in basic microbiology, infectious disease became a natural area for concentration. I chose the Harvard Medical Service at Boston City Hospital as a good place to train in internal medicine and infectious diseases with Professor Maxwell Finland and other great clinical research professors. An interest in a career in academic medicine and research was developing, aided by a two-year program at NIH where I worked on problems related to the antigenicity of the new polio vaccine developed by Jonas Salk.

Nancy and I returned to Rochester with our young daughter Kathy, and I took a position in the Department of Medicine and Microbiology, passed my Boards in Internal Medicine and began to do some research and teaching and consulted on infectious disease problems in association with Dr. Morgan. The Department of Medicine did not have an infectious disease unit, and so Dr. Morgan and I saw most of these problems. We were not compensated for this work, since it was considered part of our full-time academic responsibility. When the Department of Medicine decided to develop an infectious disease division, I went back to teaching and research full time. This ended my formal clinical responsibilities.

When I consider the impact of the various aspects of my life and training, several points stand out. I have had two great role models for the service part of my life. My father was and my wife is a model for how individuals can make a difference in the life of many patients. The clinical training at Rochester stressed the doctor-patient relationship. The internship and residency at Boston City was the most intensive and the highest caliber clinical training experience I can imagine. Compensation for the service provided was the high caliber of the medical training we received and the outstanding medical graduates who were our constant companions. Top-notch patient care was not only delivered by all but was expected of everyone. Quality control of medical care was carefully monitored by residents and attending staff who weren't the least bit afraid to criticize. Constructive criticism and clearly expressed expectations were an integral part of the training.

This brings me to address the question of how the contemporary changes in medical practice have affected the doctor-patient relationship. I think it can be summed up like this: medicine is no longer a profession of care-giving but a business of care-giving. The insertion of third parties between the physician and the patient has caused disconnection in the relationship. With medical insurance has come high technology, high expectations for cure of the incurable and an erosion of the position of the physician in the medical care equation. Third party operatives second-guess the decisions of the direct caregivers. Patients have become clients or customers. Physicians have become just one more member of the medical team. With high-tech medicine have come high expectations and increased litigation when these expectations are not met. This is amplified by the fact that the patient deals not with a personal physician, but with the medical system.

I blame the advent of medical insurance for much of the problem. The payment by insurance for most medical care interposes a third party between the physician and patient. Without the incentives of market forces in this primary transaction, cost decisions are transferred to third party.

Consider other types of insurance. Auto insurance is for accidents - it does not pay for oil changes and new tires. Similarly, homeowner's insurance does not pay for a new roof. Insurance is purchased to protect against catastrophic phenomena and the premium paid is commensurate with the risk. Medical insurance is now used as an

installment method to pay for everyday upkeep as well as catastrophic illness. Personal responsibility to govern spending is lost - someone else is paying!

The outcome of these trends is to depersonalize medical care and to require that expensive care be rationed. This trend can only continue to erode the doctor-patient relationship and to degrade the quality of health care for all but most affluent.

The only solution I can see is to return health care decisions to informed consumers and cost-conscious physicians. Health insurance would then cover catastrophic illness and more serious or expensive chronic illness, with a high deductible. In order to cover the deductible, individuals, employers and, in the case of the poor, the government, could fund "medical savings accounts" (MSA), with which the patient would pay for services and drugs on an individual basis, negotiating with the provider for a fair price.

Finally, we should consider childbearing as a planned, long-range family decision, which could be amortized over a reasonable period of years. Treat it as the family investment it really is, rather than the catastrophic event it frequently is.

It is clear to me that the social engineering of the past 30 years has failed our society and we should be aiming our reforms at the problem, which is the disconnect between the patient and his/her physician. Larger government programs or more managed care can only lead to higher cost or rationing of care with escalating unhappiness with the care availability and its concomitant increase in malpractice law suits. We should get it right this time!

