

Challenge to the Medical Profession

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David Kluge was born in Buffalo, NY, and graduated from Colgate University. After medical school, he completed general surgical residency at the University of Buffalo (E.J. Meyer Memorial Hospital) and service as medical officer in the U.S. Navy. He was in solo private practice as a general surgeon for 35 years at The Genesee Hospital in Rochester, NY, and a Clinical Assistant Professor of Surgery at the University of Rochester School of Medicine and Dentistry. Throughout his career his special interest was emergency medical services in which he trained medical students, resident physicians, and other health care personnel. He created a regional organization called STEP, Society for Total Emergency Programs, and developed a regional multi-county Emergency Medical Services (EMS) Directory, which is published annually. In retirement, he is working with the Dept. of Software Engineering at Rochester Institute of Technology to extend publication of similar regional EMS directories throughout the country. As a member of the NYS Department of Motor Vehicles Medical Advisory Board, he heads a committee to develop a scale enabling driver licensure based on medical conditions affecting driver safety.

Background.

In Rochester, NY, after World War II, our medical school Class of 1954 began studies in 1950 at the University of Rochester School of Medicine and Dentistry, 25 years after the school began. The primary emphasis of our medicine education was A) to learn about the disease process and the treatment available, and B) to learn about patients and how to care for them. This is now called the biopsychosocial model – to use Dr. George Engel's term.

On our first day our Dean, Dr. George Whipple, told us that the class was carefully chosen. He told us to do a good job and we would graduate. He also said that we should be aware that our tuition fee covered only about one third of the costs of our medical education. The university covered the rest. We should therefore consider that we were each receiving 2/3's of our tuition costs as a scholarship. The implication was obvious. A close friend of mine was attending another medical school and was told at the beginning that 10% would not be around for the second year! What a different attitude. Our teachers nurtured us in Rochester.

After graduation, a general surgical residency in a 1,000 bed university county hospital was vigorous and challenging. It was a museum of pathology and trauma for six years. The focus was on doing your best for the patient without cost consideration, although the budget was tight. The Navy experience, as chief of surgery at the Submarine Base at New London, CT, was similarly rewarding and stimulating.

In 1962, the family returned to Rochester where I became an instructor in surgery at The Genesee Hospital with special attention to the Emergency Department (ED). Weekly surgical morbidity and mortality conferences were begun along with teaching medical students and residents. Administrative experience was gained in a growing emergency department and provided income for a family of six. After two years I began solo private practice in general surgery.

24/7 for 35 years.

The practice experience for 35 years was exciting, very satisfying and rewarding. There were occasional aggravations with hospital administration and insurance companies but these were

minor compared to the constant effort of trying to do your best for the patient in the emergency department, the operating room, the office, the nursing home and later in the newly developed intensive care unit.

The special interest in trauma and the emergency department spawned a continuing effort to improve the care of patients before they arrived at the emergency department. In the early 1960's physicians and hospitals sadly neglected the whole area of pre-hospital care and paid little attention to patients until they arrived at the emergency department (ED). Fortunately the importance of EMS and the ED are now recognized. Patient treatment is now initiated at home, or at the roadside and maintained enroute to the hospital by EMS personnel in ambulance or helicopter. A record of treatment now accompanies each patient to the ED.

The past 15 years, however, have witnessed dramatic changes in patient care. There are four areas worth mentioning, but only as prologue to the challenge for the medical profession. Physicians are taught to be objective scientific observers and independent thinkers, inspired by Professor Edward Adolph's query: "How would you design an experiment to answer that question?" It is important to arrive at a conclusion independently. Therefore, consensus is not easily attained within a group of physicians. That is the strength of the medical profession and also its weakness.

Area 1. Health Maintenance Organizations.

HMO's in Rochester are a combination of physicians, hospitals and health insurance plan administrators. Only the physician part of this organization is asked to withhold a percentage of an agreed-upon charge or salary. A better plan would be to withhold the same percentage from the insurance administrators' salaries and the hospital charges. The plan administrators require efficiency by which they mean having physicians see more patients per day in less time than formerly. This is not exactly the biopsychosocial model that allows a patient-centered office visit and, indeed, may lead to inefficient care. HMO's now negotiate rates with each hospital. This has led to hospital mergers, hospital closures, advertising and patient competition. One HMO has now become a private company, designed to return a profit on the back of sick patients. Rochester is no longer upheld as a model of health delivery.

Area 2. Health Care and the Government.

Health is the absence of disease. Health care therefore should be the promotion of public health measures by government to prevent and reduce disease among the population. This has been chronically neglected. Medical care is too important to be left in the hands of a government composed of politicians, most of whom were trained for three years in the legal profession to become skilled in adversarial management. Promises are made to win elections, medical care expenditures are limited and medical care is sacrificed.

If the government were serious about reducing our health insurance costs it would take the following steps:

- 1- Pass laws that reduce salt, sugar and fat consumption by reducing their addition in food products. Result: a reduction in individual weight, atherosclerosis and diabetes.
- 2- Eliminate tobacco subsidies and reduce the sale of tobacco products to adults as well as to children. Result: a reduction in cardio-vascular problems, pulmonary diseases and cancer, as well as a reduction in burns and fire-related deaths.
- 3- Reduce or eliminate use of illegal "drugs." Result: safer communities.
- 4- Decrease use of alcohol. Result: a decrease in alcohol-related injuries and deaths including family violence, transportation incidents, fires and drowning.
- 5- Eliminate use of guns and ammunition not used for hunting. Result: safer communities.

6- Provide helmet laws for all activities associated with head injuries. Result: safer activities.

Think of the reduction in medical costs, health insurance premiums, the reduction in hospital beds, suffering, and premature deaths if these steps were taken. Hospital emergency departments deal mostly with those problems that can be reduced dramatically by the above suggestions, problems that could be drastically reduced with proper public health measures.

Area 3. Medicare.

After 1945, the concept of universal health care became a political promise. In fact, politicians claimed that it was the peoples' right. They won. With federal tax and Social Security money available, the cost of health care shot up quickly. It no longer became the problem of patient and physician working out a cost-effective way to handle illness and hospitalization. It no longer became necessary for communities, private hospitals, county hospitals and health departments to figure out how to finance improvements. The federal money was there in an abundant supply, with an abundant health bureaucracy. After 40 years of this approach we are faced with fiscal restraints on the health care system that politicians cannot digest.

Area 4. Medical Liability.

Medical liability insurance premiums have been escalating in the past 30 years as patients and their attorneys found deep pockets. When the premiums exceeded the annual cost of my office rent in the 1970s, I realized it was out of hand. This concept of a windfall for pain and suffering was fed by the increasing acceptance of big prize ethics. Its appetite increased with the *\$64,000 Question*, the Reno, Las Vegas and Amerindian casinos, state lotteries, racetracks and legitimized gambling. Liability awards for dramatic presentations in front of 12 people are the same type of game. This spawned the practice of second-guessing physicians using the retrospectoscope. The consequence was an increase in defensive medicine that increased medical costs by using additional and clinically questionable tests. I attribute my never having been sued to full discussion of the medical issues with my patients and their families – and to good fortune.

The above four concerns are reasons that those of us with a longer perspective are apprehensive about current trends in medical practice that impede patient care.

Reflections.

We were fortunate to have practiced medicine in the fifty-year post-World War II era of expanding medical research and knowledge stimulated by National Institutes of Health grants. The black bag became obsolete. Residency programs and medical specialties flourished. Medical costs were reasonable.

Tomorrow's challenge will be to provide, with limited resources, increasingly sophisticated and complex medical care and regimens to an aging population.

It can be done! Necessity requires innovation. It is important for the medical profession to lead by communicating with our patients, our non-medical peers, and our legislators. With proper information, people will see our motivation and our better answers. Hopefully, the nation and government will respond accordingly. It depends on our ability to lead and communicate. Will physicians take the lead?