

Every Time I Start This I Sound Like Some Old Guy Lamenting the Loss of the Good Old Days

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Robert F. Willkens was born in Brooklyn, NY, and served in the U.S. Army from 1945-47 prior to receiving his Bachelor of Arts degree at Antioch College. He received his postgraduate training in Internal Medicine at the University of Washington and specialty training in Rheumatology at Columbia-Presbyterian Hospital in New York City before returning to Seattle to join the University of Washington faculty. He has served for 38 years as a member of the Department of Medicine's Clinical Faculty and has maintained a half-time private practice in Rheumatology. This arrangement permitted him to carry out both laboratory and clinical research, which included pioneering studies on treating rheumatoid arthritis with methotrexate and epidemiological studies assessing genetic factors in the prevalence of rheumatoid arthritis among the Yakima Indians of Washington state. He currently continues as Clinical Professor of Medicine and is a Master in the American College of Rheumatology (ACR). In 1999 he received the Distinguished Rheumatologist Award from the ACR for outstanding contributions in the area of patient care, clinical scholarship, and service to benefit patients with rheumatic diseases.

I am having a hard time responding to the request for a personal 50-year retrospective of medicine. Every time I start this I sound like some old guy lamenting the loss of the good old days. It may also relate to the fact that "the world is too much with me." That is, I am still in it and am having a hard time stepping back far enough to get the long-range picture.

The climate of medicine when we left medical school was certainly a friendlier situation than the one which a physician enters now. I was fortunate in being able to fulfill a concept of combining a medical practice with teaching and research at the university - each on a part-time basis. In all of these pursuits I found helpful individuals - colleagues who welcomed and helped me get started. In practice, older physicians sent me patients for second opinions, consults, or just "starter" patients. In the lab at the university, established researchers lent me equipment, personal and even grant funds to get started. I had teaching opportunities at all levels: in-patient, outpatient, and didactic lectures to multi-levels of learning in both the University and out in practice. It was a fun time; here was across-the-board cooperation. It seemed like being a physician was like being a part of an ongoing game. We all had the common goal of being healers, of winning against a common adversary - illness. It sounds trite now but it turned work and long hours into a satisfaction that was almost sufficient reimbursement for our effort. Sure, we made jokes about the avaricious surgeons, but they were part of our team too. It was easier to have dialogue with many professionals with less effort. We all prided ourselves on our clinical skills and loved applying them. We felt obligated to have a broad enough knowledge base to handle problems outside our specialty. Making the patient well and enjoying doing it was our end-point. Making money was important - but seldom the primary goal.

Currently much of that collegiality is gone! Doctors are often adversaries now. The development of "a primary care base" mandates controlled cooperation between peers. The subtle unspoken guidelines include "Don't refer out of your group." It would be encouraging to think that the current retreat to "primary care and general internal medicine" is a return of the renaissance man - the likes of Dr. Clement Finch and Dr. Jacob Goldstein. But I don't think it

represents more than an accommodation to a financially driven system that eliminates greater use of specialty-trained (and more expensive) physicians, a broad knowledge base is not important - technology has supplanted physical diagnosis- and volume is the watch word. But, technology has unquestionably improved diagnosis and therapy and has improved care. It detracts from some of the games we played -- but it gets the job done, however, with less personal attention and without the laying on of hands (and sometimes without the benefit of thought).

Research these days tends to be more basic, less stimulated by specific patient-related problems. The Ph.D.s can do it better (a little resentment here) but the inquisitive clinician has been taken out of the loop. His place, it seems, is to take care of a clinical problem more than addressing the question of why illness occurred. Asking questions and being involved in clinical research was enjoyable for me over the years. Now funding for clinically based problems has become almost non-existent.

We are asked to consider patient care a commodity, which is limited, and to apply it with regard to community resources more importantly than to regard for the individual. That is not new; it has always been a consideration with respect to unachievable goals with severely ill patients. But the constraints we are now asked to impose are often for the ultimate benefit of third parties for their profit. Once again, it gets harder to get close to the patient and there are conflicting rules to the encounter which eliminate the spontaneity and mutual pleasure of the encounter. It just isn't as enjoyable as it used to be.

I cannot envision a different life's work that could have been as satisfying for me. It is only because I am aware of how enjoyable it was that I have reservations about the question of whether I would choose medicine if I were starting now. I feel fortunate that my choice was made in a more advantageous time.