Reflections on Practicing Medicine

There has been, sometimes in not such a subtle fashion, a shift in emphasis in what is meant by "medicine." The profession was regarded as a combination of art and science. Motivation for a young person who was considering entering the profession employed both the desire to become skilled in the personal contact with future patients as well as becoming learned in all the medical sciences. The armamentarium, or pharmacopoeia, was simple and straightforward. Medical schools helped students become familiar with every aspect of the limited number of drugs that were available for use. At present, as soon as a popular drug goes generic, other companies flood the market with their look-alike version. It is impossible for a practicing physician to keep up with this plethora. It is equally impossible for the U.S. Food and Drug Administration (FDA) to adequately assure safety, let alone efficacy for new drugs. Much of the time spent with patients was devoted to education and the imparting of clinical knowledge. A good doctor-patient relationship was a two-way street, enabling both doctors and patients to learn from each other. Doctors had the ability to diagnose abnormalities. Patients needed to develop an understanding of "health" first, before being able to begin to evaluate "sickness." The best source of this information was their doctor whom they trusted and felt comfortable visiting.

With the advent of medical insurance and having to weigh service against cost, we began to consider the business aspects of medicine more and service less. The Health Insurance Company sets its standards for physician reimbursement and treatment–what it will pay for–based on accepted "medical science." Currently, we are having a rash of pharmaceutical companies being brought to justice for conducting fraudulent clinical testing studies of FDA-approved drugs. There is talk of "alternative medicine" but for practical means, the theme is: there are those who dispense medicines and then there are others. This narrow approach excludes a practicing physician from utilizing tried and proven methods, such as nutritional approaches, that are not in the code books of the insurance industry. If a treatment mode does not have the "science" backing, it is considered quackery.

Instead of medicine being regarded as a service profession, it is now an industry. There is concern that few new medical school graduates are going into primary care–family practice, internal medicine or pediatrics. The primary care doctor is the low man on the financial totem pole. He/she often acts like a triage doctor who provides tentative diagnoses, prescriptions and sees that patients are shuffled off to the most appropriate specialist. There is little chance for the development of a trusting rapport. And all the "fun" of a good practice is missing, such as the opportunity for real problem solving and the feeling of a job well done. A proposed solution for the problem is based solely on getting primary doctors a bigger portion of the financial pie. This won't work. Figuring out how to increase job satisfaction will. And amazingly, when allowed to practice good medicine, we will deal with real costs, which will plummet.

The technology employed by specialists is spectacular, but costly. It has led to the medical industry in the U.S. to become our number one employer, since each medical machine requires highly trained (though narrowly trained) technicians to run it. Employment is good. What is not so good is that all the impressive razzle-dazzle pulls patients away from a "personal physician" who could efficiently coordinate care.

Our legislators are stymied by trying to contain or reduce medical costs simply because they only consider the costs of health insurance premiums. We have talked for years about putting, on a federal level, a $200,000 cap on medical liability claims and having panels to ferret out frivolous claims and still allow for examining the possibility that true medical malpractice has been committed. I am certain that the reasoning is sound.

Physicians are ordering costly tests where simpler tests would do, mainly to cover their

tails that are subject to being cut short from a frivolous lawsuit. A conscientious physician will tell you as much. The public is generally sold on the industry's purported need for the most "state of the art imaging" in order to enable an accurate diagnosis.

All doctors need to be compensated for time spent in teaching their patients how to take care of themselves. The 15-minute visit for a patient with a new complaint is insufficient. Educational advice that could help in the future is a non sequitur in a brief visit. Most clinics have ancillary medical personnel supplying only the little bit of instruction relevant to the visit, further fragmenting the physician's authority and ability to develop rapport. Patients starting on a new medication can find no way to report a suspicion of harmful side effects. This dependence on medicines while rejecting health education has gone on too long. The road back, after a turn around, will be slow. Any bit of a turn around will pay big dividends as cost savings. I am appalled in seeing that nutrition education is not only neglected but rejected. I see television ads for glucose lowering drugs for Type-2 diabetes, being touted by a grossly over-weight doctor with a stethoscope around his/her neck. "Physician heal thyself." (Or, if preferred, "Doctor, think about being a good role model.")

A powerful tool for pushing medicines or drugs has been the industry's Madison Avenue approach to use television ads for drugs, but also individual doctors (of all stripes), hospitals and clinics. Not too many years ago this was unacceptable behaviour that was condemned by the American Medical Association. Added to this is the despicable practice of lawyers inviting their TV audience to participate in a class action suit against a pharmaceutical company that put an imperfect drug on the market. The modus operandi has worked very well for the medical industry. Dazzle the public with images of "science" and technology in action: patients entrapped in a MRI tomb; robed doctors and technicians in the operating room, with the patient somewhere in the middle, hooked up with wires and tubes to various implements manned by operating room technicians. Make it clear that we have the only answer for disease–medicine. A little knowledge will get them in the fold; so make sure, in describing a disorder, that they feel more comfortable knowing the same acronym that we use (such as ACS for acute coronary syndrome). Don't confuse them with too much detail about the disorder spelled out from the acronym. After they understand what they have, tell them to ask their doctor (or is it "to inform" their doctor) about the medicine. Since there are at least five of these ads during a 30-minute evening TV news broadcast, much of the 15-minute doctor visit could be consumed by these questions.

Thoughts from an evening TV news watcher: "Sometimes I cough and feel a little short of breath. I think I might have what doctors call COPD. I'm not concerned, because there is a medicine I can take that provides relief; so I am advised to ask my doctor about it. It makes me wonder, though, what did people who had trouble breathing do before these break-through medicines became available?" I usually hear a soothing female voice going into quite a bit of detail describing side effects, some of which are pretty hairy. I tend to ignore this since I feel assured that the FDA would not permit the sale of an unsafe drug. However, I once heard a practitioner of orthomolecular medicine suggest it might be best to turn the volume down when the person with the stethoscope draped around his neck is giving his sales pitch, then turn it up and give the side-effects your full attention. The doctor said that although death might be a rare side effect, it is one that should be avoided.

I am afraid that the Norman Rockwell version of the kindly physician has passed on, never to be resuscitated.

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