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REGARDING PRIVATE PRACTICE

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There are about 70 million people in this country who were born since VJ Day. Half of our population is under the age of 25. Within five years there will be 90 million people under the age of 21 and about 21 million over the age of 65, meaning that 50 per cent of the population will be either too old to work by legislative disqualification, or too young to work because they are still being educated.[1] The rest of us in between must look after their needs and pay their bills, so I think we should make the wisest possible use of our money in financing these needs.

In addition to the change in size and distribution there is a great change in the affluence of the population. This too creates interesting problems. As there is more affluence there is less indigency and this poses a problem in connection with medical education: there are less patients on the staff or public services, traditional sources of teaching material in the training of physicians. Also as people have more money, they demand more services, including those of physicians. Services formerly considered too expensive are now being sought, some of them necessary, some frivolous, perhaps. Hopefully, with increased affluence there will be less need for government subsidy of medical care.

Technological advances have eliminated a number of diseases, and many others can be successfully treated so that patients survive longer with them, thus increasing the number and proportion of chronic diseases. As infections are conquered, for instance, there is a proportional increase in other conditions: accidental injuries, diabetes, degenerative diseases, mental diseases, arthritis, etc.

We have also seen the rise of the interesting political philosophy that health care is a right. I think the medical profession agrees that no one should go without health care because of inability to pay for it. However, views differ as to how far this principle should extend, to whom it should apply, and what methods of financing it should be used.

High quality care connotes competence, which requires a continuing supply of top grade medical students, a continuing review, and modification where necessary, of the educational methods used in teaching these students, plus stimulation and improvement in facilities for continuing the education of the physician once he gets out into practice.

Until recently there was a drop in the number of medical school applicants. A variety of reasons have been advanced, running all the

way from the competition of more glamorous professions to the threat of physicians being reduced to the status of government employees. However, the trend has now been reversed and there is a resurgence in the number of applicants for medical school, and medicine is again gaining as a favored field among superior students. This trend must be continued. It will take money, and the money to provide schools and scholarships must come from a variety of sources, including the government, but not solely the government. Recruitment of students requires emphasis on the attractions of medicine as a career, which include the freedom of physicians, the self reliance and individual responsibility, plus the other attractions that exist: for the practitioner, the pleasure of taking care of sick people; for the professor, the satisfaction of teaching; or for the researcher, the joy of discovery. Medicine must continue to attract the best students and everything we are able to do to accomplish this is important.

With regard to the teaching of students, it is scarcely possible to compress all the knowledge we have into four years of medical training. It is also almost impossible to contain, let alone retain, all the information that is poured into the medical student as the absorption tolerance reaches its limit; so curricula must be scrutinized by educators as they consider what might be eliminated, or what might be abbreviated, or what might be expedited, or modified, or taught more effectively. Western Reserve University in this city has a new curriculum which has attracted a great deal of favorable national interest. In other parts of the country there have been suggestions that the medical curriculum itself be shortened, or that brighter students be admitted to medical school with less pre-medical education. I believe that fundamentally it is important that medical students, just as other students, be taught how to learn, and not merely crammed with a lot of facts and information. Also important is the need for continuing education of the practicing physician. After his medical school course, internship, and residency, the physician secures his license and he has really scaled the heights; he has arrived! But keeping abreast of the explosion of knowledge is an extremely difficult job, even if he is living in an academic atmosphere. There is certainly no lack of stimulation: boards, academies, colleges, special societies and various other certifying groups encourage him to improve his knowledge and ability and keep them up to date. The Academy of General Practice is the only one, I believe, which insists on evidence of continuing study to maintain certification in the group. A man who becomes certified receives higher grade and pay in the Army; hospital privileges and staff appointments are favorably influenced by certification. Once admitted to a hospital staff the physician's competence is challenged continually by credentials committees, tissue committees, medical records committees and utilization committees — all healthy, constructive devices, and in the public interest. Certainly no group is more self-critical or demands more of its members than the medical profession, and this must continue.

So far as methods of continuing education are concerned, there are assuredly enough journals, commercial publications, post graduate courses, refresher courses and meetings. However, there might be more attention given to other methods such as closed circuit television, tape recordings, FM radio networks — these have been tried and there is a future in them. I would make one plea: in the frenzy to keep the up-to-date, up-to-the minute knowledge flowing to the doctor, we don't overlook the humbler procedures such as: thoughtful history-taking, careful physical examination, wise selection of pertinent laboratory tests and sensible, practical, as well as brilliant, treatment.[2]

We are interested in the availability of medical care. This, of course, implies an adequate supply of physicians, skilled in the various professional fields, and strategically distributed. The population growth will almost certainly outstrip the supply of doctors who can be graduated. Then too, the number of graduates who go into research and teaching will further reduce the number who are available to render medical care. There is a certain amount of maldistribution of those who do go into practice, depending upon economic attractions, environmental allure and the like. Specialism itself causes some maldistribution of medical care as some special fields become overcrowded and specialists congregate in larger cities, so we must make the best use of the present supply of doctors. There should be some extension of group practice to improve the quality and availability of care. Maybe the delegation of some functions, now performed by physicians, to technologists of some type is advisable. Notice that I specify technologists, not second-class physicians. Means should be sought for encouragement of physicians to settle in places where they do not now go. Possible enticements include financial subsidy, development or publicizing of educational, cultural, or recreational opportunities.

Regarding the cost of medical care — there have been remarkable advances in systems and methods of meeting health care costs. They don't yet include all people, it is true, but prepayment plans, union health plans, other consumer group foundations — all have exerted tremendous and beneficial effects on medical care and its distribution. Last and by no means least, government underwriting has entered the picture on a broad scale, often properly so. As mentioned before, no one should be denied health care because of inability to pay for it. The medical profession is in agreement that government revenue should be used to finance health care *when other measures have failed.* I also believe, as does the profession, that all levels of government should help with this whenever they can. Maximum use should be made of insurance and prepayment mechanisms. The quality of care provided people by these methods should be equal to that which

the private patient receives. Government assistance should be state administered rather than federally administered.

There should be some eligibility requirements, and they should be simple, realistic, fair and easily applied. I do think that financing health care for one segment of society regardless of need, at the expense of all other people, some of whom are in near need themselves, is philosophically wrong. I believe it is the responsibility of physicians to encourage the expansion of prepayment and insurance plans. They should encourage in every way the wisest possible use of taxpayers' money in financing health care. They should co-operate with others in the health field in avoiding duplication and over-building of health care facilities.

The future will require and will bring continuing changes in medical practice. Doctor George James has divided the practice of medicine in four stages:[3]

(1) the promotion of health — by influencing ways of life, habits, diet, applications of principles of eugenics, etc. It is possible, he points out for example, to save more lives from lung cancer by changing smoking habits in the population than by surgical attack on cancerous lungs. Probably we can influence atherosclerosis by diet — weight reduction, at least, is helpful.

(2) Pre-symptomatic diagnosis of disease — screening procedures for tuberculosis, for glaucoma, for cancer by Pap tests, for diabetes by urine and blood tests, etc. This field is receiving increasing attention; it has enormous possibilities.

(3) Curative medicine, most dramatic, most publicized, probably most attractive to the majority of physicians, most successful in tangible results in many diseases, yet still inadequate and unsuccessful in many degenerative and malignant diseases.

(4) Rehabilitative medicine, which is often a matter of teaching a patient how to live with what he has wrong with him, by use of prostheses, of physiotherapy, by changing his attitude, or his mode of living, or his way of earning a living, etc. The most need for improvement in health care is in numbers (1), (2), and (4).

Improvement can occur, and will occur if several things happen:

(1) if these fields become attractive to physicians

(2) if people will go to physicians for such services

(3) if people will and can pay for such services.

In summary, I am sure we must continue to provide quality care; we should improve its availability at realistic and reasonable costs. No doubt science will advance, as it has, and the economics of medicine will improve, as they have. It's essential that they do. I hope we won't neglect the art of medicine. I would not want to see the fascination with a disease completely exclude our concern for the poor fellow who has it.

1. Macy, Josiah, Jr., Foundation Review: Economic and Social Aspects of Medicine, 1906.

2. Miller, Geo. E., The Continuing Education of Physicians, *New Eng. J. Med.* 269: 298, 1963.

3. James, George, The General Practitioner of the Future, *New Eng. J. Med.* 270: 1287, 1964.