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Proceedings: Conference on the Responsibility of the Physician in a Changing Society

Hugh E. Dunn

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SCOPE

JOHN F. SHEEHAN, M.D.

Dr. Sheehan, Moderator of this Conference, is vice-president of the new Loyola University Medical Center at Hines, Illinois. Dr. Sheehan has been a Loyola faculty member for 27 years and chairman of the pathology department from 1940 to 1952. He had been dean of the Medical School since 1950, and in addition, is responsible for the teaching, research, and patient care activities in the University's new medical center.

The topic of this conference is the responsibility of the physician in a changing society. It is to be taken up from three standpoints, or perspectives:

1. From the standpoint of the community
2. From the standpoint of the government (public health agencies)
3. From the standpoint of the physician

I thought I might start by mentioning some of the factors that have caused change in society and as a correlative, similar factors which have changed medicine and, in so doing, have had an effect on society and posed problems for it. I have listed four: (1) the rise of science and technology, (2) the rise in the economic level, at least here in the United States, (3) emphasis on group action and interaction, and (4) the role of government.

With regard to science and technology, I think one of the most marked effects has been the change from an era of therapeutic nihilism to one of profound activity in the area of drugs. This immediately brings to mind discoveries such as sulfa drugs, and later penicillin, which have brought an increase in longevity and the disappearance of many of the acute diseases with which we were afflicted, leaving us now with an aging population and a heavy preponderance of chronic disease. These in turn have presented problems on an economic level to the various agencies in the health fields.

Another effect of science due to the tremendous growth of new knowledge is, the fragmentation of medicine and the rise of specialization. Because of the expensive techniques that came from the attendant technology, emphasis has been placed on the hospital as the focus of health care as against the doctor's office and periodic visits to patient's homes. Technology has given rise to a large variety of paramedical personnel and various other health professions besides medicine. It has led to an increase in the number of physicians functioning full-time in institutions with a concomitant decrease in the number going into private practice.

Because of the great rise in the economic level, money has become available to the population in general, for services as against satisfaction of basic needs. Because of the ease of communication and its efficiency, individuals know what health care facilities are available, as well as their adequacy. Because people can pay for services, there is an increased demand. Furthermore, we have reached a point where people think they not only have a right to life, liberty and the pursuit
of happiness, but also a basic right to health. The cost of providing the type of care the American people feel they are entitled to, has stimulated various groups, public and private, to attempt to relieve the individual of the burden of complete payment for health care. The first of these “third-party payers” was the private pre-payment plan. Later the government became a third party. These are some of the factors that have to be reckoned with as we consider the role of the physician in a changing society.

In addition to the increased efficiency of medicine, the enhancement of public health, and the rise in the economic level, another factor has led to a greater demand for physicians' services — the marked increase in the population which many believe will outstrip the capacity of medical schools to provide a sufficient number of physicians to provide adequate care. The increase in the number of aged has also increased the burden on physicians because this age group requires and demands more care.

There are also other factors that have disturbed the traditional relationship of the physician to his patients: the mobility of the population and access to groups and centers because of ease of travel. (Individuals no longer need to consult a physician in their immediate neighborhood. They can go to a center or a clinic group.) Urbanization has contributed. Finally, there is little doubt that we are in a period in which individuals, at some sacrifice in personal relationship with physicians, are inclined to approach institutions, predominantly hospitals, for definitive medical care.

REGARDING THE COMMUNITY

EDWARD H. deCONINGH

Mr. deConingh is partner and chief engineer of Mueller Electric Company in Cleveland. He has long been active in Cleveland health and welfare activities, is president of the Cleveland Community Chest, and chairman ex-officio of its executive committee. He is a former United Appeal chairman and a past president of the Welfare Federation of Cleveland. He is currently a member of several of the Federation's committees, and is a board member of many welfare and educational institutions.

I have been asked to present a community evaluation of how well the health needs of the community are being met and what future prospects seem to be. I don't have any standing, no one elected me for this. I don't represent any organizations. I suggest that if what I say meets with your approval, you say that I studied my background material well. If you disagree with me, you can say I just plain don't know the score.

If you look at the Cleveland health system, you can view it in several ways. First, the type of service it has — prevention, diagnosis, treatment, rehabilitation, long term or terminal care. Then, there is the locale of the service: is it in-patient, out-patient service, or service at home. Then who is the provider of the service? This is professional personnel in the institutions or organization through which you work — physicians, dentists, nurses, hospitals, nursing homes, health agencies. Finally, I think we should think of the financier of the service — the individual himself or a third-party payment through government, philanthropy, or insurance organizations.

I think it fair to say that health is a joint responsibility which is shared by the individual and the community. The individual carries the responsibility for himself and his family to develop habits, attitudes to undertake practices conducive to good health, and I think it is his responsibility to arrange to use the available health and medical services in so far as his abilities permit. On the other hand, the community carries the responsibility for making programs and services available for him. Thus, the community has a responsibility (1) to develop and maintain a system for diagnosis and treatment of the acutely ill, the chronically ill, the disabled, (2) to maintain and promote good sanitary environment to live in, to protect against communicable diseases, and the other health and safety hazards of that kind, (3) to inform the public about health and the resources that we have for health in the community, and (4) to plan and to develop efficient and coordinated systems which will ensure that all these resources are available to the people, and even more important, are properly utilized by the people for whom they have been made available. And that sometimes is the most difficult part of the story.

I think our community has assumed its responsibilities well and if we look at the provider of services, we see 2400 physicians, 1270 dentists, 7000 registered nurses plus what are called the ancillary group: