Don't let medicine lose its soul!

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As I leave this beautiful planet to journey to distant worlds, I am filled with two conflicting emotions—gratitude and distress.

Gratitude

Medicine has been good to me in more ways than I could have imagined when I applied to medical school as a Stanford undergraduate in 1959. It brought me into contact with smart, dedicated colleagues whose professional competence inspired me for four decades. It taught me discipline, empathy, and the thrill of connecting with people from all walks of life. It gave me the responsibility of caring for many different patients, whose problems and fears ran the gamut from the trivial to the fatal, and whom I tried, not always successfully, to serve. At two institutions—the Division of General Internal Medicine at UCSF and the Robert Wood Johnson Foundation—I was privileged to lead a talented and idealistic group of men and women who tried to make the world a better place. True, many of the problems we attacked, such as the lack of insurance coverage for millions of deserving Americans and the scourge of substance abuse, were daunting. But the effort was a worthy one, and it was invigorating to work for virtuous causes.

It was also my good fortune to enter medicine during a golden era. The seeds of scientific investigation have yielded a rich harvest, and today we can do much more for our patients than when I started my internship at Boston City Hospital in 1964. Scientific progress was assisted by major public health gains in tobacco control, motor vehicle accidents from drunk driving, environmental lead control, and dietary changes that resulted in major declines in death rates from cardiovascular disease and increases in life expectancy, as well as major improvements in functional capacity. Our population has never been healthier, even with the ravages of HIV/AIDS and the alarming epidemic of obesity.

The passage of Medicare and Medicaid ensured that elderly and poor patients previously dependent on charity could enter mainstream medical care. Segregated hospitals were forced to integrate their wards to receive federal funds. The combination of effective medical care and funds to pay for it spurred a boom in medicine, and the public turned from asking, "Will going to a doctor really help me?" to "How can I get as much medical care as I need (or perhaps, want)?" For physicians entering practice, choices were abundant and financial security was assured.

Our profession, essentially a white, male, and middle class one when I joined it, is now greatly enriched by the full acceptance of women and the partial inclusion of underrepresented minority groups.

Patients are evolving from passive vessels into which physicians poured professionally-dictated diagnostic and therapeutic nostrums, into informed consumers who share in decision making. I believe that better outcomes will result.

Distress

So this explains my sense of gratitude: that I have worked in a profession with amazing rewards and even brighter promise. What accounts for my distress? To put it bluntly, I am concerned that medicine is in danger of losing its soul. I fear that medical care in the future may be technically excellent, but emotionally barren.

At its core, medicine is a deeply personal experience. Let me give three personal examples of what I mean by "the soul of medicine," beginning with my mother, who slowly faded away with Alzheimer's disease, nurtured by my father in the El Cerrito home she lived in for 50 years. Dad was dedicated to doing all that he could for Mom, and it was hard for him to accept her inexorable decline. Fortunately, they had an excellent general internist, Ann Stevens, who—as luck would have it—had been one of my residents and later a faculty member at

UCSF. Ann gradually brought Dad along, kept Mom stable, and in the end had the good sense—as well as the knowledge of what other health professionals could do—to refer her to home hospice. Mom died at home, comforted and in familiar surroundings, and Dad felt he had done the best he could for her. Ann won't win any awards for what she did, and her payment for those services was minimal. But she understood our family dynamics, did the right thing, and, in my view, practiced medicine with soul.

My second personal example involves our son David. When he was a third-year medical student at the University of Medicine and Dentistry of New Jersey, he discovered during his internal medicine clerkship that he had found his niche. He worked hard, took good care of his patients, and had the opportunity to present one to his ward attending, Richard Mann, a nephrologist on the full-time faculty. The night before, David had been up with a sick patient, and did not feel he had adequately prepared for his case presentation. Afterwards, Dr. Mann approached David in private and commented that he seemed a bit down. When our son explained that he wished he had been able to prepare better, Mann put his hand on David's shoulder and told him, "You are going to be a very fine doctor." This quiet act of humanity from a busy teacher, which touched our son's heart, is another example of soul.

Finally, there is my colleague and friend, Steve McPhee. Now Steve is a legendary general internist at UCSF whose medical knowledge is encyclopedic and who is famous for his careful and comprehensive patient care. But he is more than that. Concerned about deficiencies in the care of patients with terminal illness, Steve and his colleagues established a palliative care unit at UCSF. In that setting, he attends to the nourishment of patients and families for whom medical hope has faded but for whom spiritual hope and comfort are still possible. Steve also edits a feature in *JAMA*, "Perspectives on Care at the End of Life," that educates physicians about care of the dying. Steve has become an inspiration to his colleagues at UCSF, and to the residents and medical students privileged to work with him.

These three examples of emotional connectedness, empathy, and caring are what I prize most about medicine.

Why is medicine in danger of losing its soul?

I am not a romantic harking back to an idealized Camelot of medicine in the "good old days," when all physicians were altruistic, sensitive, and empathetic all of the time. Anyone who was a premedical student in any college during the past half century knows that is poppycock. Like you, I have seen too many instances of ugly, self-serving behavior, even among the brightest and best-educated of our colleagues.

What I do fear is a sea change that will make soulful behavior—generosity that springs from our best impulses—increasingly rare. Why might this happen? The causes are multiple, and I would like to enumerate five of them:

1. Financial pressures
2. The loss of control over how medicine is practiced
3. The erosion of medical generalism
4. Medico-legal concerns
5. The lack of effective medical leadership.

1. Financial pressures

As the margin of profitability in medical practice shrinks, it becomes harder to absorb uninsured or underinsured patients. As a result, many well-meaning physicians are closing their practices to all but the well-insured. The reality is stark: 44 million people lack health insurance today, 74 million lacked coverage for all or part of the past two years, and many others have such bare-bones coverage that seeing them costs us money. These numbers will surely increase in the next few years. The result is that many—if not most—practices will be restricted to the financially secure. While understandable, such segregation weakens the moral basis of our profession.

Two other fiscal realities distort medical practice. One, medical student indebtedness, affects mainly younger physicians, who today graduate owing about $100,000 and often marry physician colleagues in similar straits. Economists argue that the return on investment of a medical education is worth it. But I am not so sure. The United States is unique in failing to subsidize medical education. Spending four post-college years with no income and mounting debt, and another three to seven with a low salary is a sad contrast to the financial status of equally talented classmates who opted for business or law careers. I admit that school teachers, social workers, and nurses—all dedicated public servants—get an even worse financial deal. But to a 33-year-old newly-minted internist still paying off debts and struggling to find affordable housing in the San Francisco Bay Area, such comparisons are

neither relevant nor consoling. The result may be a devastating combination of resentment, bitterness, and a self-serving sense of entitlement. The same phenomena, of course, drive career choices toward more remunerative specialties.

The final financial problem is an old one: how physicians are paid. The pro-technology biases of fee-for-service payment are culturally familiar and endure in spite of numerous attempts at payment reform. These biases denigrate the nontechnological aspects of medicine, while creating perverse incentives to use technologies. It is hard to practice under such incentives without becoming cynical, venal, or both. In addition, the payment system creates disincentives for focusing on the difficult but crucial aspects of chronic disease management such as pain, the emotional aspects of illness, and death. Not only are important tasks poorly reimbursed, but the incentive for procedures makes doctors concentrate on technological answers for personal and spiritual issues. Patients understand this, and it contributes to their loss of trust.

I offer three remedies, each easier to articulate than to achieve.

- The first is *universal health insurance*. It is a moral outrage that this rich nation consigns millions of people to charity medical care. The situation has persisted for so long that we have become numb to it, both as a nation and as a profession. How we get to universal coverage is less crucial to me than that we do not settle for the current situation. Ultimately, of course, the solution depends upon leadership. I will return to this.
- My second financial reform is to *reduce medical student debt*. This could be accomplished through a combination of increased scholarships, loan forgiveness in exchange for public service, and stricter oversight of how tuition dollars (for private medical schools) and state subsidies plus tuition (for public schools) are spent.
- The third remedy is to *change the financial incentives* that encourage excessive use of medical technology, while discouraging time-intensive services. There are two ways to accomplish this—capitation and payment reform. Capitation had a brief heyday during the managed care boom of the 1990s, and is still vibrant in the Kaiser system. Fee-for-service payment reform currently is stalemated because the bodies that arbitrate it are represented in the same way as the U.S. Senate, with small specialties like urology and ophthalmology having the same power as large specialties like internal medicine and family medicine. Even internal medicine is ambivalent about payment reform, because it is split between procedure-oriented sub-specialties like cardiology and gastroenterology, and time-intensive ones like infectious diseases, endocrinology, and rheumatology.

2. The loss of control over how medicine is practiced

Medicine is clearly in transition from its old days as a cottage industry with each physician on his own (and I use the male gender advisedly), to a group effort that benefits from the latest information technology, accessible medical records, and better communication between patients and multiple health professionals. Both patients and doctors have much to gain from such modernization.

At the same time, health care has expanded from a small field costing less than 5 percent of GDP to an industry that consumes more than $1.5 trillion, 14 percent of GDP. Now that medicine is big business, doctors have lost much control over what they do. They often work in large institutional settings where decisions about hiring and supervising staff, setting schedules, and adjudicating personnel disputes are made elsewhere, usually by nonclinicians. Systems that control telephones, billing, medical records, and appointments often seem chaotic and dysfunctional. Patients frustrated by impersonal bureaucratic barriers often vent their anger during the medical visit. Another factor leading to our sense of loss of control is the evolution of the role of patient from passive to active. Although shared decision making does weaken traditional medical authority, the net result, I believe, will be better clinical outcomes.

Part of the solution to the loss of control may be self-correction, as medical informational technologies, telephone systems, and billing systems become more user-friendly. Doctors must take the lead in helping to design and implement better systems, to insist they be put in place, and to assure that our performance does not depend primarily on a good memory. We also need to accept the reality that the new prominence of medicine, coupled with the newer generation of informed patients, will mandate more sharing of decision making.

One area in which I see room for reform is in billing. It seems insane for practices to have to cope with so many idiosyncratic billing forms, coverage details, pharmaceutical formularies, referral restrictions, and so on. Short of the elegant simplicity of a single-payer health insurance plan, there should at least be standardization and simplification of claims forms and procedures, which sap time, energy, and money to no clinical benefit.

3. The erosion of medical generalism

As a card-carrying general internist, I am a firm believer that many—not all, but many—patients do best in a longstanding relationship with a medical generalist. Yet, as you all know, the pendulum has swung away from generalism toward specialism. When, or even whether, it will swing back is anyone's guess. Patients will ultimately determine whether they derive sufficient value from the coordinating, integrating, and technologically unbiased services generalists provide. Tomorrow's medical students will decide whether they will choose to brave the challenges and insecurities of breadth over the more comforting certainties of depth. As cost-shifting to patients accelerates, the negative connotations of medical gate-keeping under managed care may be replaced by the cost-benefit counseling of generalists who serve as trusted advisers about the utility and frequency of costly tests and procedures.

If medical generalism fails its market test, I fear that something very precious will have been lost. I am not so chauvinistic as to claim that soul is unique to medical generalists. Indeed, we all recall specialists who went (and go) the extra mile for their patients and their colleagues. But I worry about specialists being so tightly linked to their procedures—both professionally and economically—that they find it harder to be unbiased advocates for patient choice. While I do not pretend that only generalists count the soul as one of their organs of concern, I believe that losing generalism would be a major blow to the compassionate side of medicine.

Are there remedies for the protection of the endangered generalist? I have already mentioned one reform that would be crucial—how doctors are paid. The other solution I offer involves the medical community. Doctors themselves send mixed messages. We steer young physicians away from generalist careers at the same time we aggressively seek the best generalists to serve as doctors for ourselves, our friends, and our families. Would it hurt if specialists were more generous in acknowledging and even promoting the virtues of generalists? I think not, and the generalists would certainly appreciate it, even if they turn out to be a dying breed.

4. Medico-legal concerns

The practice of medicine is inherently risky. For severely ill patients, the margin of error between therapeutic benefit and disaster is razor thin. On top of that, patient expectations have evolved from accepting bad outcomes as uncontrollable acts of God, to assuming that behind every bad outcome stands a culpable physician. No group is more aware of this attitudinal shift than our colleagues in obstetrics. There is also the grim reality that far too many potentially avoidable errors occur.

The response to an adverse event is often a lawsuit—a process that can devastate a clinician. Among the responses to being named in a medical malpractice suit are thoughts about leaving medical practice, clinical depression, and even suicide. The system response has been to embrace the false security of practicing costly defensive medicine.

The remedies for the malpractice problem are complex and multifactorial. We should concentrate first on reducing the risk and occurrence of medical errors through a combination of system reforms borrowed from other industries. At the same time, we should focus special attention on the relatively small number of physicians who seem to have a disproportionate number of bad outcomes. But reducing the error rate will not be enough. We must also reform the malpractice system itself, most likely through some combination of arbitration and no-fault mechanisms. And, by the way, physicians who are perceived as being more caring have lower rates of being sued.

5. The lack of effective medical leadership

Notice that I did not say "loss" of leadership. In an earlier time, the medical profession exerted effective leadership through the American Medical Association, which too often used its power to prevent social reform of medical financing. The AMA was successful in blocking health insurance reform in the period from 1932 to 1964, and almost succeeded in killing Medicare and Medicaid.

Today the AMA is a shadow of its former self, its power eroded by declining membership, a series of disastrous business and management decisions, and the competing forces of medical specialization. It would be nice to say that some other group has moved into the medical leadership void. But that has not happened. True, organizations like the American College of Physicians, the largest of all the medical specialty societies, have supported good causes such as health insurance expansion. But the bulk of the lobbying efforts of all medical societies have focused on more narrow specialty concerns, to the exclusion of broader issues such as health insurance reform.

Conclusion

Without effective leadership from the profession, what will the practice of medicine look like 20 years from now? Here is my vision: technical excellence, improved safety, and better outcomes, but in an emotionally barren context, leaving too many patients and physicians unfulfilled and unhappy.

Here is the single message that I want to leave with you: Don't let the soul of medicine vanish from our profession. If we permit medicine to slide into a technocracy, we will be guilty of helping it lose its soul. Somehow, too many physicians have become overwhelmed by the circumstances of medical practice, and have lost sight of the values that drew them to medicine in the first place.

I have tried to outline steps that I feel are needed to preserve medicine's soul: economic reforms including health insurance expansion, medical student debt relief, and physician payment revisions; better technologies to process clinical encounters so as to enrich physician autonomy; the preservation of medical generalists; and medical malpractice reform.

Central to each of these is restoration and revitalization of medical leadership, a daunting prospect to a profession struggling to maintain the status quo. But without such reforms we may face a future that is even more bleak. Please help to preserve the soul of medicine for our children and grandchildren.

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