Letter from . . . Chicago

Of great place

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Love of power and the craving for advancement lie rooted deep in human nature. They spur men on to great enterprises, confer mixed blessings on mankind, and reward the ambitious spirit with pleasure, glory, or pain. This letter treats of those who seek power and lose liberty, and of those who climbed to the top but find the standing slippery. The modern corporate executive belongs to the first category; medical politicians, professors of medicine, and consulting physicians to the second.

The predicament of the first category was recently described to a group of members and aspiring members of the second by Dr Charles P Newmann, a psychiatrist, under the title of "The rise and demise of the corporate executive." It is the story of a "success syndrome," and the setting is a society which equates success and achievement with rank and money, and expects men to pursue these goals relentlessly. The outcome is often disappointment, and sometimes mental breakdown. Family and friends may suffer a "domino effect."

Conformity and competition characterise the life of modern corporations, and Dr Newmann sees a need to humanise these institutions. He describes Versailles-like glass towers where all offices look the same, and where 16-page instruction books prescribe even the permitted size of family photographs. Lesser executives occupy smaller offices on lower floors, and compete for promotion to high rank, a large suite, more money, and more status. But with promotion the executive's problems increase. His life becomes more stressful and complicated. The new job demands more work, the new house in the suburbs longer commuting. He comes home tired in the evening, increasingly his work takes up his weekends, he spends less time with the family. Admission of weakness or stress, however, would jeopardise chances of further promotion. After all, the others do the same work and have no complaints. The continued tension is allowed no outlet other than perhaps the occasional somatic symptom. Eventually the situation comes to a head, often in the late forties, when the executive realises he is not going to rise to the top.

The sense of failure, coming after decades of struggle and tension, may lead to severe mental breakdown, profound depression, alcoholism, or attempted suicide. Dr Newmann's remedy is removal from work and home, and voluntary admission to a psychiatric hospital for two or three months of psychotherapy. Another approach, however, is to sue, and an executive who drank his way to the top of the corporate ladder, and whose promotions were apparently related to his ability to hold his liquor during business functions, has claimed a million dollars in damages from his corporation for turning him into an alcoholic and not helping him overcome his problem.

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So much for those waylaid en route by ambition and disappointment. For those who rise to the top and wield great influence on the national medical scene, a recent study attempts a more precise measurement of bigness, influence, and "the uncontrollable propensity of telling other people what to do."[1]

The medical big daddy

The study concerns a distinct type of medical leader, the Big Daddy, described somewhat irreverently as a certain species of power broker, always watching over others, often pompous, and usually surrounded by an indefinable aura which conveys the feeling that he has "cornered the market in wisdom." Other features are said to include the "use of a language that combines the worst of business and psychological jargon, the professional smile often observed in politicians, the invariable tendency to call everyone by their first name, and, most commonly, the extension of the arm over the shoulder of whomever the Big Daddy is addressing." Further refinement of the Big Daddy factor system depends on whether the subject is actual (A), aspiring (A_1), exhausted (E), or eternal (E_t). Ranking is on a scale from one to ten. Among the examples we find Abraham Flexner, father of American medical education, rated $E_t=10$. Further down the scale, the authors have placed Dr Michael DeBakey (A=9); Senator Edward Kennedy (AA_1 E=9); Dr James Sammons, of the American Medical Association (AE=8·8); Dr Morris Fishbein (AE_t=8·1); Dr Franz Ingelfinger, of the *New England Journal of Medicine* (A=7); Dr Donald Frederickson, of hyperlipidaemia fame (A=5·5); and Dr Alexander Schmidt, commissioner of the beleaguered Food and Drug Administration (AE=4).

Yet so slippery is the standing at the summit that already we note the resignation of the four highest rated health officials in the country: Mr Caspar Weinberger, secretary of Health Education and Welfare, formerly (AE=8·5); Dr Charles Edwards, the assistant secretary (A=8·5); Dr Henry Simmons, deputy assistant secretary (AE=8·4); Dr Robert Stone, director of the National Institutes of Health (A=9). Clearly, frequent updating of Big Daddy ratings will be necessary.

Some form of updating, or rather downgrading, will also be needed for the chairmanship of the department of medicine. Once regarded as the pinnacle in internal medicine, this post is typically occupied by a highly competent man in his forties or fifties who commands an average salary of $54 000 per year, a budget of $2·5m per year, and a staff of roughly 160 people. His influence is great but his responsibilities are overwhelming, thus confirming Francis Bacon's observation that to seek power over others is to lose power over oneself.

The problems of this exhausted Big Daddy were recently surveyed by Dr Eugene Braunwald, himself chairman of medicine at Harvard. The survey showed that the halflife of a chairman now averages four years. Eighty per cent leave their position prematurely, or die in office. Thirty-three per cent regarded their job as detrimental to family relationships; 36% had seriously considered resigning within the last year; and a

mere 15% expected to stay in office until retirement. They worked roughly 72 hours a week (almost 40 in administration), but spent a mere four hours in clinical activities and two in direct research.

Dr Braunwald deplored the loss of an important model for young physicians, because the leading positions in clinical medicine are occupied by tired men, who regard themselves as unsuccessful and are thus perceived by their deans, peers, students, and children. Suggested solutions include smaller professional units and more skilled administrative "physician extenders." Meanwhile, an earlier proposal to kill the professor of medicine has come closer to its realisation.[2]

Decline of the attending physician

Also in decline is the consulting or attending physician in the teaching hospital. On the wards of the public "charity" hospitals he has long been inconspicuous—perhaps because he is too busy in the laboratory or in private practice. During the recent house officers' confrontations with hospital administrators the consultants pitched in somewhat, but their collective voice was relatively muted. And in Atlantic City, at the meeting of the "Young Turks," Dr Robert A Kreisberg showed a caption from Pogo which read, "We have met the enemy and he is us."

He suggested that difficulties in recruiting young people into careers of biomedical research antedated the more recent cuts in federal funds, and might reflect disenchantment with academic medicine and with the prevailing pressures and the systems of rewards, which emphasise research, specialisation, and political manoeuvering at the expense of teaching and patient care. In a recent survey the students rated their faculty as only 60% satisfactory. When house officers realise they that are better doctors than their teachers; when their professors come late for rounds and talk only about their special interests; and when mediocre research takes precedence over clinical excellence—it is no wonder the young people become disenchanted. They listen to the constant down-grading of the practising community physician, see that within a short time they too will be second-rate citizens at the university, and soon become alienated from academic medicine.

A similar note was struck in the presidential address to the "Old Turks" by Dr David E Rogers. He made a plea for restraint in the application of modern technology to diagnosis and therapy, and for a more careful evaluation of possible benefits to the patient. He referred to the high cost of medical care, to the rising incidence of iatrogenic disease, and drew a parallel between the case of former President Franklin D Roosevelt, who died from lack of effective antihypertensive drugs, and that of his late wife Eleanor, who succumbed to iatrogenic disease—acute disseminated haematogenous tuberculosis after corticosteroid therapy. Dr Rogers deplored the all too frequent emphasis on a "complete diagnostic work-up," and pointed to the need for generalist consulting physicians who know when to call a halt.

He concluded that insistence on a complete diagnosis had promoted the flight of young physicians into subspecialties, that the generalist was not a luxury in the second half of the 20th century; that specialists were needed only where there are also non-specialists; and that the time had come to assert the philosophy that sins of commission are as bad as sins of omission. It was a pertinent address, but it displeased a prominent investigator (and, incidentally, chairman of a university curriculum committee), who on the way out from the auditorium commented, "Well, wasn't this a waste of time?" There, at least, is one medical school where change will come slowly.

But, whatever the problems of "academic" medicine, the private physician in the teaching hospital is not faring any better. Indeed, here is another fallen Big Daddy, "hankering for the respect and homage that once attached to his image," and a victim of the traditional but intensified town/gown feud.[3] He experiences new and changing relationships, with housestaff and nurses, full-time faculty and administrators, and the laymen who have strangely appeared on review and management committees. To the older physician, who remembers that seated nurses would rise when he entered the room, the present scene indeed represents the accelerated change which causes role disorientation and "future shock."

Wherever he looks his influence has been eroded. Yet he vainly looks for signs that the new order is better than the old, and he sees a world where decisions are increasingly made by administrators and planning committees; where doctors are becoming merely another column in the corporate table of organisation; and where patients get short shrift because commonsense is wanting. He is bombarded with memoranda and regulations, attends endless meetings that achieve nothing, and on the wards he can barely fight his way to his patients through the crowds of students, house officers, full-time faculty specialists, and allied professionals. In some hospitals he is not even allowed to write orders, but only suggest them to the resident, and it appears that some physician/house officer relations make the Israeli/Arab situation appear cordial.[3] If he complains, he is listened to, but not understood, or he is told to put it in writing for the bureaucrats. And, though he may console himself with maxims about the inevitability of change and the need for flexibility, he may also be tempted to muse upon the "end of medical dominance,"[4] and to reflect once more with Bacon that truly "the standing is slippery, and the regress is either a downfall, or at least an eclipse, which is a melancholy thing."

References

[1] Dwelly W P, *et al*, *The New Physician*, p. 19, January 1975.
[2] Peart, W S, *Lancet*, 1970, **1**, 401.
[3] Gordon A, *Physicians World*, 1973, April p. 44, May p. 37.
[4] Lister, J, *New England Journal of Medicine*, 1975, **292**, 906.

An institution for disabled children has had one or two cases of infectious hepatitis. Blood tests for Australian antigen showed that one adult member of the staff, who is not clinically ill and has no history of previous jaundice, was positive. What is the likelihood of her developing hepatitis and is this likely to be serious? Have immunoglobulins any place in preventing the development of the clinical condition?

If the staff member has been positive for the hepatitis B surface antigen (Australia antigen) for over three months the chances of her developing acute hepatitis are minimal. She could well be a completely healthy carrier, but it is important also to exclude underlying chronic hepatitis since this may be present in the absence of clinical symptoms or signs. The standard liver function tests should be carried out and if any abnormality is found then liver biopsy is indicated to characterise the lesion present, for this may require treatment with prednisone or other immunosuppressive drugs. Specific antibody to HBAg is commonly used in preventing clinical illness after accidental innoculation of positive blood, but in patients with established HBs antigenaemia infusion even of large doses results in only a temporary reduction in the serum titres of the antigen. Such an approach is unlikely to be of value in the completely healthy carrier, in whom there is a very high concentration of the antigen in the liver as well as in the blood.

What is the "Ling-Lee" operation for hip arthroplasty?

The Ling-Lee operation for hip arthroplasty is a total hip replacement with the acetabulum component made of high-density polyethylene. The femoral stem is of stainless steel or is now available in Vitallium. The operation technique is that of a posterior approach and is a pure replacement operation as opposed to the Charnley low friction arthroplasty—which goes further than total hip replacement and is, in fact, a total hip reconstruction using the lateral approach, raising the greater trochanter, and then replacing it in a slightly different position.