Letter from . . . Chicago

Chilling times

GEORGE DUNEA

British Medical Journal, 1979, 1, 184-185

It was recently announced that, plans for the purchase of the United States having been completed, the Saudis are expected to move into the White House by the next Ramadan.[1] Within a year Arabic will be the official language and Islam the true relition. Defrauding Medicare, prescribing useless drugs, and removing lily-white appendices will be punished by the morals police in the usual manner, but the department of public aid will supply, free of charge, artificial hands and plastic ears for the victims of the new austere penal code. Nurses will wear veils and long robes; welfare recipients will travel by camel instead of expensive taxis; alcohol will be removed from cough mixtures and geriatric tonics; everybody will be required to fast during holidays; and ward rounds will be interrupted for the prescribed devotions. Curriculum committees will plan a lecture series on Avicenna and Averroës, and endlessly wrangle over the introductory course on Harun-al-Rashid. At least three anatomy professors are expected to develop transient ischaemic attacks on learning that their lectures on the pterygopalatine fossa have been replaced by a course on Arab socialism. Yet all these calamities might have been averted had the President and his disobedient Congress worked out in time an acceptable energy programme to avert national bankruptcy.

But instead they argued and procrastinated, forgetting not only about the national deficit but also about the approach of the perpetual winter. And indeed even the Arabs might forget about moving into the White House or lugging those glaciers from the South Pole to Jiddah, for the glaciers are coming anyway, and soon our summers will be gone for ever. We have been lucky indeed, according to Mr Robert Ardrey, to live in a gracious interval between the ices, for rarely in the past half-million years has the weather been as propitious as in our times, and few interglacial periods have lasted much longer than 10 000 years.[2] Many times before the glaciers have retreated, causing the oceans to rise and changing the tundra to forests and grasslands—notably some 124 000 years ago, when Greenland was green, Neanderthal man roamed freely through Europe, and the hippopotamus grazed in Britain. But each time the ice returned, and it will happen again, for our present warm interstadial is already some 12 000 years old. So it is only a matter of a few years, perhaps a few thousand, before the winter's snow will fail to melt, and Chicago will lie buried under a mile of ice. With Mr Ardrey we shall miss shopping on Fifth Avenue, wandering along the Seine or through the Ufizzi, or eating crabmeat in San Francisco. Instead, we shall be huddling, true believer and infidel alike, around the fire in a cave in Katanga, and only the hardiest of the race will survive to complete the journey from the present halfway house between ape and superman.

Cook County Hospital, Chicago, Illinois
GEORGE DUNEA, FRCP, FRCPED, attending physician

Suburban discontent

Nor is it expected that the glaciers will stop at the outer confines of the city and spare our felicitous suburbs. And already during these last few interstadial years it has become apparent that life in the suburbs is no longer untroubled, and that crime, drug-taking, and juvenile delinquency are no longer the exclusive monopoly of the inner city. Worse still, sociologists have now discovered that far from providing an ideal child-rearing environment, suburbia isolates youngsters from diversity and contact with people of diverse backgrounds, providing few opportunities for the child to display emotions, solve problems, or assume community responsibilities. So that suburban life, with its emphasis on wealth, comfort, safety, and the automobile, is in fact boring and without challenge for many able but alienated children. And the child psychologists, turning their microscopes on some of these rich children, have found that most pass without fanfare from their prepubertal phase of altruism to the realisation that this is a cruel world, where big fish eat little fish, and where it is better to be a big fish. Thus an unjust society perpetuates itself through the indoctrination of its young, and not surprisingly many rich children can conceive of no more effective way of holding on to their entitlement than to take up studying law.[3]

Periodically, however, some of these alienated youngsters break with tradition, move to Nepal or into communes, or riot in the streets to reform society, such as happened at the time of the Vietnam war, the assassinations of Robert Kennedy and Martin Luther King, and the 1968 Democratic Convention. For the radical doctors of those times, 1978 was a nostalgic ten-year anniversary of the height of a heroic era, when they took over the deans' offices, insisted on relevance in their curricula, published militant newspapers, set up store-front clinics, brought medical care to the slums of Chicago and the backwaters of Mississippi, and seized the hospitals to serve the people. It was noted that while many of the promises remained unfulfilled, much has been achieved in obtaining better care for the poor, jobs for minorities, and effective affirmative action programmes.

But the heroes of a decade ago, now aging radicals in a society that is moving to the right, have had chequered careers. Some have passed through the Marxist phase and become planners, administrators, sociologists, or professors of preventive medicine, content to try changing society from within rather than from without. Others carry on as though time had stood still, still organising community groups and outreach programmes. And others have considerable difficulty in adjusting to changing times and unfulfilled expectations, and remain discontented and confused. But the modern medical students of 1978 have little understanding of these former heroic times; and they are concerned mostly about their education, their debts, their future, and their prospects in an increasingly regulated medical system. Perhaps some day in the future they will again rebel and march for the betterment of society. But for the time being most of them will study, complete their training, and move out to practise in the suburbs.

Staying behind, sometimes in areas that bring to mind the bombed out cities of the second world war, are the old academic

centres, the universities and their hospitals, swamped with enormous patient care responsibilities, struggling with rising costs, union demands, and federal regulations, and having grown so large as to be administratively unwieldy and strangled by their own internal bureaucracy. Once the hub of American medical research and learning but now victims of their own success, they are being put out of business as referral centres by their own graduates, now practising in attractive and well-equipped suburban hospitals. Their vastly expanded and increasingly expensive house staff contributes in no small way to their high operating costs; and with the disappearance of the voluntary attending physicians the full-time faculty has become overextended, and in many cases has effectively left the house staff in charge of the ward and clinic patients. To these problems must be added the government's constant demand for turning out more primary care physicians, a task requiring considerable readjustment from institutions whose very raison d'être was specialism and advanced care.[4]

Professional reinbursement

Faced with a difficult problem the university departments and their chairmen have tried to adjust. Rather than publish and perish,[5] many academic departments have evolved into group practices and service corporations, with part of the professional fees earmarked for research and departmental activities. But private practice in the ghetto is not like private practice in suburbia. Even setting up an appointment system for patients accustomed to waiting all day and being called through loudspeakers constitutes a tour de force, as is completing the paperwork and collecting the fees from the various governmental agencies. To which must be added the recent codification of the government's perception of how to reimburse teaching hospital doctors for professional services rendered to patients covered by Medicare.

The debate over professional fees goes back several years and arises from the difficulties in separating true clinical services from activities related to teaching, administration, and supervision of house staff. This issue was left vague in the original Medicare legislation, which stated merely that teaching hospital doctors would be reimbursed for clinical services rendered. Since teaching hospital doctors were legally responsible for anything being done to their patients, they felt entitled to bill for all services rendered, even though most of the work was actually done by residents. But the government took the position that, since it was reimbursing costs, it was already paying for the services of the house staff. In addition, the hospital doctors' salaries were also partially included in the calculated Medicare costs, so that an argument could be made for double or even triple billing for the same service.

In 1972 the amendments to the basic Medicare law mandated the Department of Health Education and Welfare to set up regulations for teaching hospitals concerning the reimbursement of professional fees. Because of their controversial nature, these regulations have been delayed five years. Meanwhile most teaching hospitals have set up private practice plans that provide not only for a considerable portion of their doctors' salaries but also leave ample sums for research and educational activities. The new regulations, issued on 1 October, in effect are so rigid as to jeopardise the very existence of these plans and create havoc in the many academic centres. Hence the intense controversy, the lobbying, and the attempt by several senators to repeal the 1972 amendments.

The new regulations, promulgated in the spirit of cost containment, are expected to save the government some $100m a year from professional fees to teaching hospital doctors. They state that no patient in a hospital may be qualified for direct reimbursement of professional fees unless at least 85% of all patients in that hospital are private—as tested by some ten criteria specified in the regulations. Thus the doctor must regularly see and examine the patient, outline and review the treatment plan, stand ready to perform any procedure that may be required, be identified by the patient as his doctor, and directly bill for the services rendered. The details of the regulations are complicated but the implications are enormous, since they would indirectly affect the reimbursement from other government agencies (such as welfare) and private insurance carriers; drastically reduce the income of the hospital doctors; and encourage private doctors to take their patients to non-teaching community hospitals. Unless modified or considerably watered down, they would greatly alter the relations between attending doctors and house-staff, and fundamentally change the way in which medicine is practised in most academic centres.

Patient-doctor relationship

Other things, however, never change, and these include the very basis of medicine, the manner in which the doctor interreacts with his patient to establish a diagnosis and treat his illness. On this subject, published simultaneously on both sides of the Atlantic, was the discovery that patients are often difficult historians, and that we learn more if we allay their fears and unconscious repressions by listening carefully, overcoming their distrust, acknowledging and sharing their anxieties, and not rushing in with inappropriate reassurance.[6] We must also help the hypochondriac but use a supportive approach without incurring his wrath by denying his illness or threatening to cure him.[7] We must learn to cope with the hateful patient, whether he be a dependent clinger, an entitled demander, a manipulative self-rejecter, or a self-destructive denier.[8] Lest we forget our descent from the medicine man, we must overcome our tendency to confuse diseases with illness; understand our patients' expectations; recognise the role of "wind disease" and witchcraft; and not be surprised if our patients are dissatisfied when we use penicillin instead of cold to treat a "hot" disease.[9] We might also rely a little more on computers, which though lacking bedside manner, are quite clever at picking up digitalis intoxication.[10] And we may have gone a little too far in our enthusiasm for teams, especially for the health care team, because doctors are rather more like pilots than cheer leaders and project directors.[11]

From time to time we need to be reminded of the mind-body dualism and of the possibility that our patients' somatic symptoms are due to anxiety, depression, hypochondriasis, delusions, or conversion reactions.[12] We must negotiate about our frequently diverging goals in the spirit of Camp David.[13] We might with advantage analyse the overall diagnostic strategies of experienced clinicians and find that some are methodical, some go straight to the core of the matter, some probe in many different directions, and some go right back to the beginning of the illness.[14] And we might even muse about some of the old wisdoms, that if you ask questions you will get only answers, but if you listen to the patient he will tell you the diagnosis.

References

1 Beck, J, *Chicago Tribune*, 27 January 1978.
2 Ardrey, R, *The Hunting Hypothesis*. New York, Bantam Books, 1976.
3 Vidal, G, *New York Review of Books*, p 9. 9 February 1978.
4 Rogers, D E, and Blendon, R J, *New England Journal of Medicine*, 1978, **298**, 940.
5 Jerva, M J, *Proceedings of the Institute of Medicine, Chicago*, 1978, **32**, 17.
6 Havens, L L, *Lancet*, 1978, **1**, 138.
7 Altman, N, *American Family Physician*, 1978, **17**, 107.
8 Groves, J E, *New England Journal of Medicine*, 1978, **198**, 883.
9 Kheinman, A, Eisenberg, L, and Good, B, *Annals of Internal Medicine*, 1978, **88**, 251.
10 Gorry, G A, Silverman, H, and Parker, S G, *American Journal of Medicine*, 1978, **64**, 452.
11 Taxay, E P, *Journal of the American Medical Association*, 1978, **239**, 1137.
12 Drossman, D A, *Annals of Internal Medicine*, 1978, **88**, 366.
13 Bernarde, M A, and Mayerson, E W, *Journal of the American Medical Association*, 1978, **239**, 1413.
14 Kassirer, J P, and Gorry, G A, *Annals of Internal Medicine*, 1978, **89**, 245.