NEGLECTED FIELDS OF MEDICAL CARE

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IT is the custom nowadays to begin a discussion of almost any subject with some reference to the age of atomic energy. A few weeks ago a colleague, serving on a committee with me, suggested that a report being composed contain the statement that "we strongly urge health protection and medical care commensurate with the great scientific achievements of this atomic age." Though in sympathy with these good intentions, I could not help but point out that in the vast rural areas of this country there are still millions of homes which lack even a sanitary privy and that these areas would be best served at this time by some pre-atomic age sanitation and even some old fashioned plumbing. Nevertheless, I, too, cannot refrain from emphasizing the obvious fact that in an age in which we have achieved the splitting of the atom for practical use, we are lagging far behind in the creation of a social organization geared to use the products of modern scientific advancement.

In speaking of neglected medical fields I mean by "medical" the total health services which must be provided in order to protect and maintain the health of our communities. This is a far wider application than the provision of medical care *per se* and involves all workers in the field of health, professional and lay. As a matter of fact the tendency to divide the provision of health services into isolated professional segments is in itself an evidence of neglect in our thinking.

Though the exact sciences have contributed magnificently to medicine and other fields of health protection I consider medicine primarily a social science. Despite the fact that pure science is constantly pushing back the frontiers of knowledge of the mechanisms in health and disease, the promotion of our collective health is primarily a social problem, the fullest understanding of which is vitally necessary to the practical adaptation of scientific knowledge. The discovery in a laboratory, no matter how brilliant and precise, of a cure for a specific disease may represent a magnificent achievement, but it would be a sterile one indeed if as a people we failed in our attempt to utilize it widely for the eradication of that disease. It is disheartening to know that in one of our forty-eight states infant mortality is as low as thirty deaths per thousand live births and, with the same knowledge available to all, it is ninety-one in another state, a frightfully high figure in this country at this time.

I think it is fair to ask of our health professions that they consider as their prime objective the maintenance of our health. Too often, however, some of

those professions have been fascinated by the concept of disease itself rather than a positive approach to a concept of health. I hope that some day we will have a more precise definition of health than that it is the "absence of disease." Physicians are given rigorous training in medical school and hospital in the characteristics of disease and its diagnosis and treatment. In most cases, preventive medicine is given little time in the curriculum and its teaching is usually by didactic lecture. Even worse we have received practically no training at all in what might be called the social aspects of medical care.

It is not difficult to understand this rather warped concept which must be overcome. The middle of the nineteenth century found us peering into microscopes discovering and defining the germ theory of disease. Our scientists went after the problem with full devotion, discovering the causative organism of one disease after another, developing theories of immunity, and ushering us into the great era of chemotherapy and biotherapy with its life saving drugs, the sulfonamides and penicillin. Biology, chemistry and physics were applied with ever greater success as those sciences themselves developed more precise knowledge. It is not surprising then, that as we figuratively broke the individual into his component parts, even into individual cells, better to understand the action of the marvelous living organism, that we should have become preoccupied with the fascination of the parts and lost sight of the man.

An individual is a biological and social organism and will lend himself only to a certain amount of precise scientific measurement. True, psychiatry is coming into its own and we are beginning to take cognizance of the individual as a total unit. But the individual lives typically in families which in turn make up communities. No disease process affects a member of a family without having a measurable effect on every other member of that family and, in due course, upon the community as a whole. In this field the medical and psychiatric social worker and the public health worker has advanced farthest, but there are those in the health professions, primarily doctors and dentists, who have lagged far behind. The slowness with which we are integrating social factors into the quest for better health represents a neglect in our thinking and planning.

What are some of the specifically neglected fields which we must retravel and by tilling and sowing them, more nearly reap our objectives. Time does not permit extensive discussion of each one. Perhaps we may be given an opportunity in our discussion period tomorrow to dig more deeply. Tonight I should like merely to point out some of the most pressing problems.

There are many problems in the fields of education and research. I shall not mention specific defects of a curricular nature, but there are two fields of neglect which affect deeply our social and economic patterns.

Whereas typically our urban communities are best supplied with health personnel and possess the greatest number of our most modern hospitals and schools, the rural areas of this country, its villages and small towns are suffering progressively from an adverse ratio of personnel and facilities in the field of health. It is no surprise that our rural areas show the highest death rates from preventable disease, have higher rates of maternal and infant mortality and still suffer significantly from malaria, pellagra and hookworm diseases which are quite uncommon to large cities.

Manifestly we need more doctors, dentists and nurses in the more sparsely settled areas and we need a better satisfactory distribution. In North Carolina for example, in 1914 there were 1,125 doctors. In 1940 there were 719 doctors in spite of the fact that the population had increased by 600,000. Seventy-three per cent of North Carolina's population is rural but is served by only 31% of the doctors. These figures are typical of a predominantly rural state. Almost one half of our young graduates in medicine come from medical schools in five industrial states, while eighteen states, mostly rural, turn out no medical graduates from schools within their borders.

It is my opinion that though we need better distribution, and this I will discuss later, we need to train more doctors. It is in obvious neglect of this that we continue to carry on discriminatory practices against applicants from minority groups in medical schools and hospitals and to make more expensive the cost of health education. Whereas we need more doctors we neglect the means by which their number can be increased. Certainly a democracy dedicated to the health and welfare of its people can not afford to sacrifice its educational opportunities to the myth of racism.

At no time in our history have we had such a favorable environment for coordinated research on the problems of maintaining health and prolonging life. By utilizing our vast resources and coordinating our investigation we were able during the war to split the atom and to produce instruments of destruction heretofore unknown to the minds of men. And yet with cancer killing more people than war each year, with twenty-three million people suffering from chronic diseases, with diseases such as the common cold and arthritis robbing us each day of many more man hours of work than strikes ever did, we are failing to attack our problems of peace as we did in war. There have been introduced in Congress bills planned to increase and to coordinate our facilities for research but they have been sidetracked time and again and there is a danger that through false economy we will forget the lessons of cooperative research which were developed during the past six years.

There is no doubt that American medicine at its best is superb. But it is also expensive. Evidently all but a small minority now agree that some method of underwriting the risks of unpredictable illness through insurance is needed. Whether that method should be voluntary or compulsory merits an entire discussion and can not be undertaken in the time allotted. While we debate the question, however, it is well to remember that there are at present relatively few people adequately covered by some form of health insurance other than hospital insurance. Meanwhile, the high cost of medical care prevents millions of people from utilizing to the fullest, services that should be available to all.

Medical care is a purchasable commodity. The number of doctors and hospital beds and other services in a community nearly always depend to a very great extent on the relative wealth of that community. The less money there is, in an area, the less service available. Doctors can hardly be blamed for wanting to settle in communities where they can find good facilities and make the best living. Hospitals can hardly be established where there are not enough doctors to staff them, or where people do not have the money to purchase hospital care, and thereby maintain them financially. It is a vicious

circle—without hospitals—fewer physicians—without physicians—fewer hospitals—without purchasing power fewer of both.

Medical expenses are unpredictable and uneven. Many families spend nothing for medical care throughout the year. A small percentage incurs heavy, and often catastrophic costs. The lower the income, the higher the proportion that is spent for medical care, and it is usual that the lower income groups have the highest rates of illness. In actual expenditure, however, rather than in percentage of income the $5,000 a year income group spends six times as much for doctor's services as those families in the $1,000 a year income group. If we all agree that we can underwrite the risk and spread the cost of medical care equally by the pre-payment method, let us not neglect doing something about it. Until we do, doctors, dentists, nurses and others will continue to concentrate in our wealthier urban areas, and the best hospital facilities will likewise be there. Until this trend is reversed by assuring adequate income and opportunity to professional people in all parts of the country, preventable deaths shall continue to occur, and neglected illness will rob us of our productivity on farms, and in mines, and industries.

For over sixty years medical care has grown more complex, and there has been a greater and greater trend toward specialization. In an age when even the large streamlined airplanes are expected to be replaced by jet-propelled planes, few of us wish to rely on the physician practicing alone, with his armamentarium complete in his traditional little black bag. No physician is expected to be proficient in all of the medical specialties. The system of referral however, is expensive to the patient, and this expense sometimes forces the physician to compromise and delay until it may be too late. Furthermore, expensive equipment is duplicated and used inefficiently, further increasing the cost of care.

The mechanism of coordinated medical service known as group practice, which pools equipment and utilizes the specialized skills of the physicians in the group, offers the opportunity of more comprehensive coverage and lesser cost, and is a way of practice that seems to be acceptable to most. Combined with the principle of pre-payment it offers a better approach to many of our health problems. Through group practice, physicians can expect better working conditions, and by working in harmony with their colleagues, a more lively interest in clinical problems is maintained. The competitive principle is diminished and economically the group has a vested interest in the *health* of its patients and a greater addiction to preventive medicine. The practice of group medicine was used extensively in the Army to the advantage of the patient, and to the satisfaction of the participating professional personnel. There are signs that this mechanism of practice is spreading, but it is difficult to shake off traditional adherence to the solo practice of medicine.

At Montefiore Hospital, we are studying the feasibility of establishing a group medical unit to provide services to families of average income who will be insured by the Health Insurance Plan of Greater New York. The hospital, particularly the teaching hospital, is an ideal environment for an experiment of this kind. The group unit in the hospital can offer comprehensive health services to a community efficiently and economically, utilizing its already existing services. The opportunity for establishing high standards of care through

coordinated services should be a challenge to the hospital to create a yardstick—a sort of TVA, if you will—of comprehensive health protection and medical care. This is a job for community planning as well as hospital organization.

Tradition and the neglect of sound social reasoning have in the past created centrifugal forces that have thrown hospital care for chronic disease, invalidism, convalescence, old age, tuberculosis and mental disease into areas peripheral to the general hospital. Though in some sense these are special problems, they are problems which have received less attention than the more dramatic acute illness. The health professions must have the opportunity to see, study, and treat the processes from birth to death as a continuous problem. To this the answer seems to be the integrated hospital, with special wards or buildings, if you will, for special problems. The hospital is best used when it is dedicated to health, regardless of one's age or condition. Mechanisms must be found for the care, in their natural environment, of those people who, in convalescence, old age or static invalidism, are often found languishing in isolated wards or nursing homes. Home care, for the convalescent, the invalid, or the aged would be less expensive when provided in the home through the community, and more humanly natural for the affected individual. Dr. Bluestone, Director of Montefiore Hospital, in discussing this subject, has said that he has never seen an invalid or aged person who was nostalgic for a hospital or a nursing home.

Another neglected area is one in which we have failed to utilize the services of auxiliary personnel, thereby saving our professional people from needless waste of time, which can be better used on the pressing problems for which they were trained. We must avail ourselves of the services of practical nurses, nurses aides, dental aides, and technicians wherever possible. In the Armed Forces they went much farther than we dare to go in civilian life in the use of ancillary personnel, and it was done with great success.

The problem of chronic disease is fast becoming the number one problem in the field of public health. As the death rates fall from the communicable diseases which are being largely conquered, people are growing older and falling prey to the chronic degenerative diseases. At present the only prevention we know is early medical care, and we must remove those obstacles, social and economic, which prevent the patient from promptly reporting his symptoms. We must also give our clinical investigators an opportunity to study the early manifestation of these diseases and to be in contact with them long enough to gain greater understanding. To do this, we must reverse the popular practice of the past of shoving these patients off for lack of interest or out of frustration, due to the failure to arrest their condition. The care of chronic disease, or the long term illness, is a prime problem for the integrated hospital.

Finally, and by no means least important we must search diligently for and study the social aspects of medical care. A person who comes for advice in matters pertaining to his health does not throw off his environment when he enters the door and his problem does not cease when he leaves the office. We must take into consideration the total environment in which he lives, and we must help him in planning his community so that it may be his servant and not his master. The great majority of trained social workers have rejected

the concept of the "Lady Bountiful," but I suspect that there are many areas in the realm of our thinking in which this concept is still extant. Those of you in the social sciences must approach community planning as it affects health in a positive manner. The habit of marshaling our forces to meet social stresses only when they become unbearable during wars and depressions must be overcome, if we are to prevent another world crisis.

I have heard it said, as no doubt you have, that the medical social worker has advanced too far, in many cases, into the doctor's area. I know of hardly any instance where the social worker has thus advanced, except into a vacuum created by the doctor himself. The medical and psychiatric social worker, the public health officer and nurse, the visiting nurse and the sanitary engineer, the medical care and hospital administrator must advance upon the schools of medicine and demand that their students be trained in the community and home as well as in the laboratory and clinic where they see in reality only part, and a very small part of the individual's problem. The trained diagnostician, no matter how brilliant, who stops short at a diagnosis of disease and offers mere directions for treatment, is in essence treating only putty, unless life is breathed into it by his understanding of the world in which that patient lives, and the dignity with which that person is invested.

I have touched upon some areas which I think neglected. I have not had the time to discuss others, though they are no less important. Housing, social security, environmental sanitation, rehabilitation, recreation and mental hygiene are other areas in which we could find many evidences of neglect. It is always simpler to point out shortcomings than to do something about them.

This is indeed a time for decision. We must produce practical solutions to our social problems, or perish spiritually, if not physically, from the results of a mechanistic science. Scientists deal with cold hard facts even though forces may be unleashed powerful enough to destroy us all. Their discipline is one of objectivity, but they have given ample evidence recently of their ardent desire that the social scientists will use scientific discoveries for the benefit of mankind. We in the professions that touch upon so intimately the daily lives of our fellow citizens have a tremendous responsibility now and in the immediate future, and we cannot afford neglected areas.