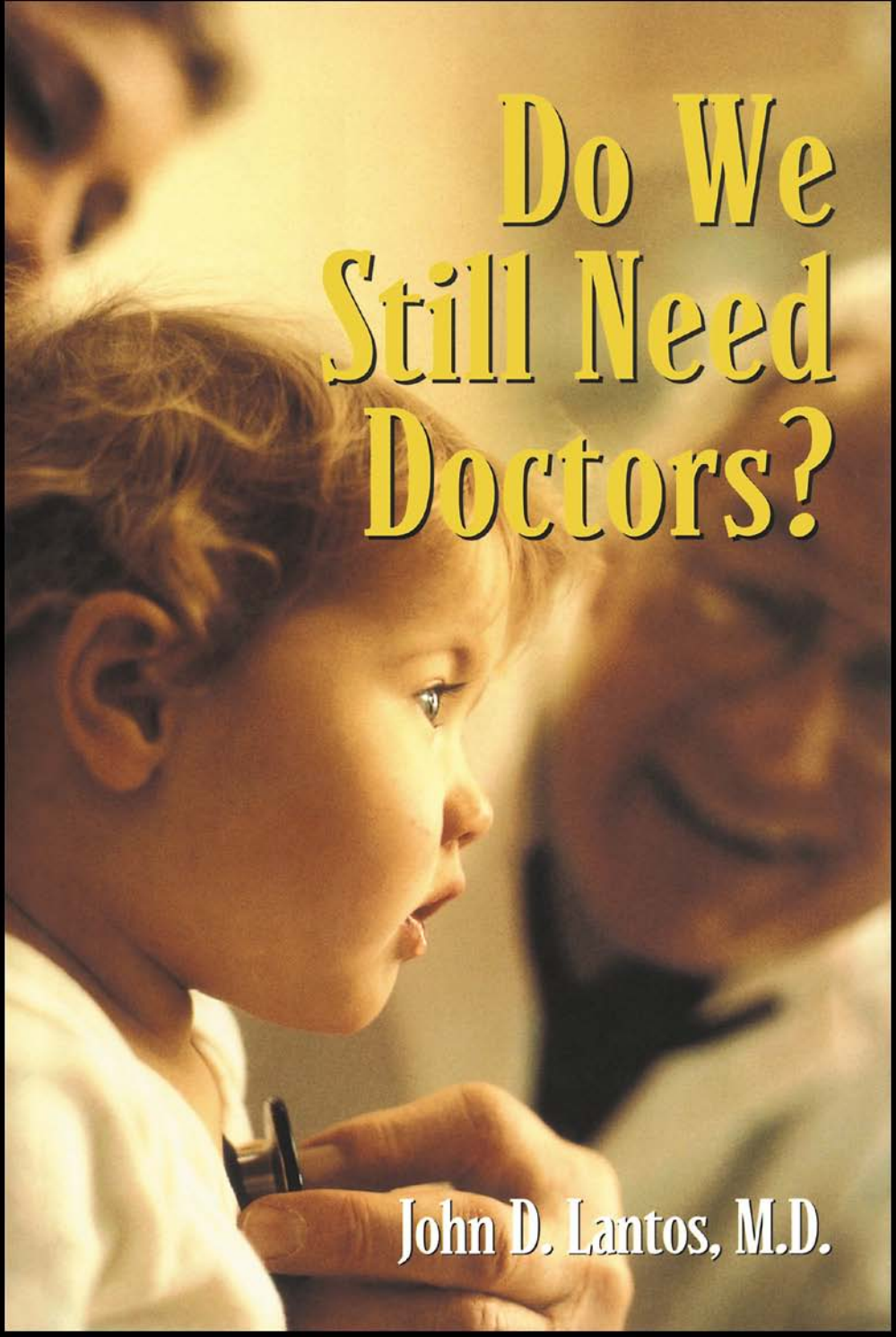

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John D.Lantos, M.D.

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This book is dedicated to my
father Raymond J.Lantos, M.D.

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1

Introduction

Do we still need doctors? The question may seem disingenuous. "Of course," the answer might go; "the sick, like the poor, will always be with us. Who else would care for them?" But to answer a question with a question would only lead to more questions, some of which might have disturbing answers. Many other professionals can care for the sick. Doctors do many things other than caring for the sick. The purpose of this book is to think about roles and responsibilities within that evermetastasizing enterprise that we call the health care system. Particularly, I want to think about what doctors do within that system, what doctors once did, what doctors ought to do, and where lines should or could be drawn to define these various domains.

To think about how we might conceptualize what does or does not make someone a doctor is to stumble into an interesting morass. We have to know not only what doctors do or don't do but also how well or poorly they do specific things compared to other professionals. We might ask whether one needs to be a doctor to deliver a baby, or to determine which types of lenses best correct myopic vision, or to counsel the emotionally distressed. Should only doctors perform physical examinations, or administer anesthesia, or determine whether a patient is ready to be discharged from the hospital? Should we leave it to doctors to determine whether another doctor was negligent in a particular situation? How do we define and measure quality in order to decide whether doctors do these tasks better or worse than other people? And how do

we decide appropriate reimbursement for the completion of the tasks? All of them have been and may be performed by doctors, but they may also be and often are performed by others.

Once we begin to ask such questions, subsidiary questions immediately spring to mind. How should we train doctors? Is the current premedical curriculum, which was developed in the late nineteenth century and which requires courses in calculus and physics but not in economics, public policy, or psychology, still appropriate as both an intellectual prerequisite and a significant part of the selection process for admission to medical school? There have been some important changes in medicine and the delivery of health services since 1890. Are internships and residencies crucial to the training of competent physicians, or are they an institutionalized and sadistic form of slave labor designed primarily to balance the budgets of teaching hospitals? Is it more important for a doctor to develop long-term and trusting relationships with patients or to develop expertise in a narrow but crucial aspect of therapy? Are there many things that doctors now do that could be done more competently and less expensively by other professionals?

In the real world of health care delivery and in the metaworld of health policy analysis, such questions are being asked, answers are being proposed, and policies that incorporate those answers are being implemented every day. Questions are asked and answered both implicitly and explicitly. Nobody knows which answers will turn out to be *right*. More interesting, it is hard even to agree about what it means for an answer to be "right." The measure of "rightness" could be specific and measurable improvements in the health of the population, such as lower infant mortality or a higher rate of vaccination against influenza. The measure of "rightness" could be the profitability of corporations in a challenging and competitive medical marketplace. It might include the satisfaction of patients, or a moral conception of what the medical profession ought to be, or an idea of the meaning of health and disease. It could be any combination of these or other metrics. Each would lead us in a certain direction. Without some sense of which answer is correct and, thus, in which direction we want to go, it is hard to evaluate the far-reach-

ing changes that we are seeing in the world of medicine, biology, and health care delivery.

Doctors sense that things are changing but can't quite understand whether they should support or oppose the changes. Many feel overwhelmed, powerless, betrayed, and angry. Part of the frustration arises because of the way that the changes are occurring. They don't seem to be the arbitrary results of whim or fashion, but they also don't seem to be the result of careful planning or accountable political processes. They seem directed and inexorable, but nobody seems responsible. They seem to have a momentum, and a morality, and perhaps even a mind of their own.

For some, the changes seem to reflect the healthy and long-overdue recognition that medicine, like other social endeavors, is governed by economic laws. There are many attempts to describe the transformation of health care using the language of business and industry—to talk of the corporatization[1] or monetarization[2] of health care. These analyses generally describe the changes we are seeing and argue either for or against them, but few attempt to explain them. Even though we have understood economics for centuries, we never before thought that it should be applied to medicine in the ways that we now do. Why now?

For others, the current changes reflect advances in clinical science and clinical epidemiology that allow us to measure what works or doesn't work in a way that we never could before. In this view, the current changes are part of a trend toward higher quality care, fewer unwarranted variations in care, or greater accountability of care. Each of these interpertations of the current changes is undoubtedly part of the puzzle, but all seem unsatisfying to anyone who is looking for someone to blame.

We like to look for villains. It might be the meddlesome government, or the selfish lawyers, or the malingering patients, or the greedy for-profit health care chains. In a sense, it doesn't seem to matter who it is, as long as it is somebody. But it might not be anybody. It may be that the changes have come about because of subtle but pervasive shifts in what we, as a society, mean by and expect of medicine and health care and the professionals who provide it. Perhaps we don't need many of the things that doctors used to do. If so, then today's changes may reflect something

more profound than market consolidation or better health services research. They may reflect a new way of understanding illness and a new way of responding to it that is so profound and far-reaching that it is both immensely threatening and damnably difficult to grasp.

Clearly, such a shift has been taking place. Countless writers have noted that a fundamental change in doctoring began as biologic science advanced to the point where medical treatment began to work. Prior to the twentieth century, medicine was a form of healing that primarily involved and inevitably required a relationship between a healer and a patient. Such medicine was a spiritual discipline for healer and patient, both of whom needed to recognize and harness the implicit and inherent powers of biologic organisms to heal themselves. Both worked to direct those powers toward certain goals. The process of healing was slow and frightening. It took patience and faith.

With advances in biologic science, we have begun to scratch the surface of a whole new domain of medical knowledge. We have learned to effectuate cures in ways that do not involve belief or human relationships. This change began sometime in the early twentieth century and led to a fundamental reconception of the role of a doctor. To the extent that the science and technology of medicine begins to work, the traditional role of the doctor can and does change from healer or comforter or shaman to scientist or technician or health care provider. Put another way, all of the emotional or spiritual qualities of the doctor-patient relationship that once were the essence of healing are no longer always necessary for healing to take place. The new medicine can work on patients who don't know their doctors or don't like their doctors. It can work on patients who are unconscious. It can make people unconscious. It can change the way people think, or see, or feel emotions.

We are just at the beginning of this new age. We are just beginning to understand the extraordinary extent of our new powers. These new powers challenge us to reevaluate the importance of many facets of traditional doctor roles. Some that once seemed central may become peripheral; others, which we may not have thought of as proper doctor roles at all, may become more and more essential.

Occasionally, biologic medicine stumbles upon a new

understanding so powerful that it changes the way we view ourselves and our lives. The smallpox vaccine has eliminated smallpox, and a scourge that was once an inherent and essential part of human existence is now history. Oral contraceptive pills have profoundly and permanently changed the way we think about human sexuality and procreation. Organ transplantation changes the way we think about death, bodily integrity, and the interrelationships between people. Anesthesia changes our ideas about consciousness, memory, and pain. With new ontologic challenges, we reshuffle roles and expectations. We will always need to deal with illness, suffering, and death, but we need not deal with them in the same way forever.

An element in each of these discoveries and breakthroughs is that the locus of healing shifts from the person of the healer to the knowledge or technology itself. Both the healer and the patient become relatively less important, and the treatment and the disease become more central. We no longer need think so hard about what the individual doctor can do. Instead, we begin to think about what the system or the health care team can do. Thus, a transformation is currently under way by which doctors are becoming integrated into large and complex teams of health care professionals. In such teams, the doctor is one player among equals. The team members include other doctors; nurses; respiratory, physical, and occupational therapists; social workers; pharmacists; nutritionists; statisticians; economists; hospital administrators; and others. These teams work together to provide high-quality care within a fixed budget to populations of patients.

When health care is provided by such teams, we might ask what the doctor's role on the team ought to be. Should the doctor be one team member among equals, the star, the coach, or the general manager? Do such teams work best when directed by a doctor or when directed in some other way? To imagine that health care teams should be directed by a doctor is to imagine that the current transition is not such a big transition after all. Instead, it is a continuation of a process that has been under way in health care delivery for a century. Doctors don't work alone; they depend on others to make the drugs and devices, to do the lab tests, take the X-rays, and change the bedpans.

To imagine that health care teams should be directed by

someone other than the doctor, however, is to imagine a world in which doctors no longer do one of the things that define the profession: they no longer give the orders. They are no longer in charge. They are no longer the locus of responsibility for decisions and outcomes. Instead, they constitute one specialized health-service-delivery profession, one with expertise in pharmacology or surgery or physiology, among many fields of specialization. Such a change would have profound implications for the meaning of the profession. It might have more profound implications for our understanding of health, disease, and healing, and for the politics, economics, and regulatory superstructure of health delivery systems. Some think that such arrangements strike at the core of the doctor-patient relationship and hence at the essence of what it means to practice a healing profession.

If we imagine such a world in which doctors are no longer in charge, we must also ask who the new leaders will be, and how we ought to think of their roles and responsibilities. If the physicians are beholden to the leaders of large health delivery organizations, or to health-services-research czars, or to the guidelines and dictates of the latest malpractice litigation, then the people who run the organizations, do the studies, or write the legal decisions will bear some of the moral responsibility that we now vest in physicians. To whom will they be accountable? And by what mechanisms?

Such a world without traditional doctors would not be a world without health care. Instead, it would be a world in which a certain set of roles and privileges that we have come to conceptualize as inherently linked to the figure of the doctor would be conceptualized differently or would be obliterated. Such a world could be preferable to the present world. Some evidence suggests that it would be a world in which health care might be better and more cost-effective. Autonomous doctors create problems. They practice in idiosyncratic, uncontrollable, and often irrational ways. They don't follow rules. They don't regulate themselves well. They act in self-serving ways. They don't respect the autonomy of competent patients, unless threatened by a lawsuit. They bristle about sensible administrative controls. They generate enormous costs, which society must bear, for projects that have dubious societal benefit. They have a medieval-guild mentality. Perhaps we would all be better off without them.

Imagining such a world of health care without doctors should be no more of a challenge than imagining a world in which we have shoes but no cobblers, trains but no engineers, farms but no farmers, or drive-through banks with nothing but automatic teller machines. Something is lost but something is gained.

The groundwork for such a reconceptualization of the role of the doctor has been under construction for decades. Specialization and subspecialization within medicine were a part of the process. Doctors themselves acknowledged that they couldn't know everything, couldn't care for patients single-handedly, needed to work in teams. Multispeciality group practices diffused responsibility for patient care among many professionals, each of whom was a physician but many of whom were not the patient's doctor. The process continued with the development of a variety of ancillary health care professions, each of which can carry out some of the tasks that doctors used to carry out themselves. Nutritionists oversee diet; social workers counsel; nurse anesthetists give anesthesia; physical therapists, occupational therapists, respiratory therapists, hospital pharmacists, psychologists, and clinical nurse specialists all have specific and specialized roles that are essential to patient care. Each takes a piece of what doctors once did and makes it his or her own professional responsibility.

These changes in the way we deliver health care prefigured and gave impetus to the current reorganization of systems for health care delivery. Some still imagine the doctor as conductor of this complex orchestra. Others see doctors as merely playing some of the instruments.

At each step along this path, there have been trade-offs. At each step, some doctors perceived that their role was being diminished and they fought the administrative changes that institutionalized that diminishment. Critics of change fought, and lost, against third-party payment, group practices, and capitated payment systems. Many are now fighting, and losing, against managed care. There is a rhyme and a rhythm to these struggles, but it is faint and difficult to discern.

The rhyme has to do with the diminishing importance of an ongoing private relationship between an individual doctor and an individual patient. Such a relationship, when it exists, can be important to healing. It requires a special human

bond. As third parties get involved in payment and reviewing records, confidentiality diminishes and the sacred trust begins to crumble. As group practices treat doctors as interchangeable, the process continues. Practice guidelines impose a rationality on this space, and it further shrivels. The rhythm of the struggles is the rhythm of twentieth-century American life, the replacement of the individual with the committee, the mass media, the bureacracy. It is a world that is both more cut off from traditional certainties and more enmeshed in its own rigid political and sociological structures.

To ask whether we still need doctors is to ask how these developments change the way we should think about the proper response to illness and suffering, how we should train the people whom we empower to respond, and how we should shape the institutions that educate those people and deliver those services. Such big questions cannot be answered head on. My responses to them will be somewhat elliptical. I will tell stories of episodes in my life and the lives of people I know in which disease and medicine played a role, and try to extract from these tales some insights and understandings about the way we now think about health and healing and about disease, suffering, and dying.

2

Postwar Optimism

A central question for the new world of medicine is whether we want medicine to be a rational, scientific, and orderly process. The new medicine aspires to these qualities. The new doctor is armed with new wonder drugs, new wonder statistics, and wonderful new analyses of cost-effectiveness and of the proper processes of rational decision making. There is a wonderfully clean and sterile hum to the modern hospital. Even in the intensive care units, calm efficiency pervades. Specialized teams draw blood, adjust ventilators, discuss the withdrawal of life support, and harvest organs for transplantation. The patients are abstracted into lab values, digital readouts, radiographic images, or moral categories.

There is something eerie and problematic about this calm efficiency. There seems to be no room for wonder itself, or terror, or tragedy. Disease and medicine touch all of our lives in intimate, profound, and frightening ways. As patients, we cannot want and don't really accept the wonderful abstraction. We insist on some recognition of our messy, personal tragedies.

Some time ago, my wife's mother, Evelyn, was diagnosed with breast cancer. She'd been living alone since her husband died of emphysema a few years before. She had nursed him through the last years of his life. As his lung disease got worse, his life closed in around him. He quit farming, then he had difficulty walking up stairs, and finally he became oxygen-dependent and was tethered by a nasal cannula to an old green metal tank that the home-health-care agency picked up