Stop tugging on my stethoscope: 
A defence of doctors

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I wish first to express my appreciation for having been invited as the Goldhart Ranney Lecturer. It is an honour indeed. I am very pleased also to have met this evening some members of the Goldhart and Ranney families. That these two remarkable men, for whom this lecture is named, were not physicians I had suspected, since doctors seldom willingly join together in anything, except perhaps to name a disease. When Dr Chris Szparaga called me, she suggested that I talk on something humorous. Quite frankly, with what is happening in the United States to medicine and physicians, it would take a combination of Albert Einstein, Jackiw Mason and Christopher Columbus to discover something comical to talk about.

From the title of my talk, you might have received the mistaken impression that I am an internist. In actuality I am a plastic surgeon who has not forgotten how to use a stethoscope, but does so only if necessity demands. The title “Stop tugging on my stethoscope” is allegorical, of course, and alludes to the harassment, not sexual, we doctors in the United States are experiencing.

It used to be said that whatever social phenomenon was occurring in the United States, Canada would soon follow. This was not so flattering to the United States since those phenomena mentioned were negative ones, eg, divorce, murder, urban violence and crime. Now, however, the situation has been reversed.

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If one listens to American radio talk shows, where everybody becomes an expert by simply dialing a telephone, and the talk master or mistress is the all knowing guru, the subject is unrelentingly health care, especially complaints about its high cost, its relative unavailability to 15% of Americans, its over-specialization, and its incompetence. In a country where, for those who can afford it, health care is the best in the world, there is, nevertheless, always a story about how a doctor missed the diagnosis or recommended an incorrect treatment. Even doctors criticize other doctors. Those critics are usually non-practising physicians who are high in academia, and who, I believe, unconsciously resent the income but not the stress of other physicians responsible for the daily care of patients. By crying mea culpa, they are rewarded by consumer groups enthusiastic to find fault with the medical profession. While these self-appointed judges of the medical scene protest that they are speaking out for the benefit of patients, many, in my opinion, are doing it more for their own benefit. To praise medicine today is a risky venture, only for the foolhardy willing to pit themselves against the tidal wave of hostility that seems to be engulfing physicians in the United States.

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It is interesting that, despite the preoccupation of Americans with cost, most polls show that our citizens believe that their own doctors do not over-charge, even though at the same time they believe that physicians in general charge too much.

The humorist Henny Youngman once remarked that when his family doctor recommended that he have an operation and he went to the surgeon who told him the cost, he replied that he could not afford it. The surgeon then offered to “touch up” his x-rays. Henny quipped also that when he saw his bill after an operation he understood why surgeons wear masks.

Americans are modest, reasonable people with regard to health care: all they want is the very best, at any time of the day or night, for everyone, but at no cost to themselves.

I am certainly no expert on health care and would not presume to propose a cure for what ails the health care system or its lack in the United States. Instead, I wish to share with you some observations, humble though they may be, on what is transpiring in my country as far as the practice of medicine
is concerned. To many of you this will not be surprising, but to us Americans, it has been astonishing bewildering and frustrating.

A short while ago, the director of my hospital, a very able person who happens also to be an internist but not a practising one, sent a letter to those of us who parked in the garage and told us that we would have to relinquish our spaces to patients and their families to make it easier for them to park. We could use the lot behind the hospital. While the change geographically was not great, it was symbolic. In stark terms, it underlined the fact that, at least in the hospital, the needs of patients came before the convenience of doctors. What an amazing and horrible thought! Seriously, one cannot really dispute that proposition since we are supposed to put the needs of patients above our own. When a doctor complained to an administrator, he beat a sheepish retreat when asked, “Don’t you care about your patients?” That was truly a magnificent speech stopper. The irony is that the current directors of the Harvard hospitals earn an enormous amount of money, patients preceded doctors. Without patients, there would be no physicians, hospitals and medical schools.

**CRITICAL TIME FOR HOSPITALS**

Now is a critical time for the United States and our established institutions, hospitals particularly. The rapid proliferation of hospitals that characterized the era after the Second World War, especially in the 1960s through the 1980s, has now been replaced by consolidation of services and by retrenching to cut costs, sometimes in a ludicrous fashion. The other day, an obstetrician, frankly overweight, stopped me in the parking lot and bemoaned the fact that the administration was no longer providing peanut butter, crackers and orange juice for a midnight snack, which that obstetrician liked when he was on duty. At the same time the hospital was now caught in the midst of a multi-million dollar building program, something that had been planned for a decade. That particular venture could not have happened at a more inauspicious time fiscally, and recently it has been significantly cut back.

As an American, I find it difficult to know what our country is really like and I submit that you in the audience have a better idea because you are supposedly more objective. At the risk of seeming simplistic, I would state, however, that one of the principal characteristics of America and Americans is optimism, the belief that things can get better and that the way to make them better is to become bigger – that everything is possible. The concept that money follows new ideas has built our nation. In actuality that belief is probably true. For the first time, however, American physicians are being told that while you may have a good idea, we cannot afford it. One’s immediate reply is that for us to make progress, it is necessary that we establish this particular clinic, buy this piece of equipment, investigate this topic or problem. But then how to do it? Where does the money come from? Bottom line thinking emphasizes the fiscal solvency of medicine but I believe that the bottom line must always be the patient; an important corollary is that we must advance continually. Whenever we take in our sails and do not set out for uncharted areas in medicine and science, the patient ultimately will suffer and will in fact be paying an even higher price; if it is not the concern of that patient and his or her generation, then certainly it will be the concern of the children and grandchildren.

While this rhetoric may sound lofty and may be correct, bills have to be paid. And obviously the money has to come from patients, the public or the government, which depends for its own resources also on the public who happen to be our patients. For the first time in American medicine, patients are becoming coequal with physicians, a remarkable change.

**PHYSICIAN-PATIENT RELATIONSHIP**

To get a perspective on today, let us consider what the relationship between physicians and patients was in the distant and not so distant past.

For most of recorded history, the relationship between the healer and the ill person involved not just a difference of knowledge but a chasm of communication. Take a relatively
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Our state and federal laws require physicians to explain in exhausting detail the risks, benefits, expected outcomes and alternatives of treatment of any proposed therapy. Patient and physician are enmeshed in the process of medicine. We doctors appear to be spending more time getting ready to treat than actually treating.

Unlike in Canada, the medical scene in America has hordes of hovering malpractice attorneys ready to descend vulture-like on the physicians of legitimately aggrieved, or even not legitimately aggrieved, patients. Although the cost monetarily of malpractice and the defensive measures taken by doctors is supposedly only 1% to 2% of the total spent on health care, the emotional cost to doctors, at least, is much higher.

In the state of Massachusetts, patients have the right to their own records from both the hospital and our offices. A few years ago, all the patient could legally wrest from the doctor’s office was a summary of consultations, treatment, etc. Now patients can have everything. This ruling I believe is sound and logical, but several years ago when this law came into being, many doctors objected, believing that the patient might misinterpret the record because of the lack of knowledge. In this regard, you will recall what Alexander Pope said: “A little knowledge is a dangerous thing.” The obvious rejoinder is: “Who has enough knowledge to be out of danger?”

A few years ago in Connecticut, it was discovered that a plaintiff’s attorney had placed one of his staff as a worker in the medical records department to sift through patients’ files, especially those from the emergency room, to find an incident worthy of his legal prowess.

These changes in the relationship between physician and patient, in the practice of medicine today as compared with just a decade ago, are characterized by not only greater communication on a one to one basis but the general democratization of medicine as a profession. Medicine used to be controlled by and seemed to belong more to doctors and their guilds and the profession. Now the balance has shifted with medicine belonging more to the people, to the public, to patients who, by virtue of their numbers, have the obvious power both politically and legally.

The patient is of course vulnerable to his or her disease and, as human beings, we all share that vulnerability. In the United States, the physician is vulnerable to the caprices of litigation. In a recent survey of Harvard Medical School graduates, at least one in five, and now perhaps one in four, has experienced a malpractice suit. But when physicians in America complain about malpractice, we should think of our colleagues of yore. For example, the physicians in Mesopotamia, 1700 years before Christ, had to abide by the Code of Hammurabi. It stated specifically: “If a physician has performed a major operation in a seignior with a bronze lancet and has caused the seignor’s death or he opened the eye socket of a seignor and has destroyed the seignor’s eye, they shall cut off his hand” (1).

Obviously a surgeon could make only two mistakes.

INEQUALITY VERSUS INEQUITY

I mentioned what I interpret to be the democratization of medicine. In that regard, one has to remember that there is a difference between an inequality and an inequity.

An inequity implies an injustice, whereas an inequality is a condition of being unequal. Theoretically and actually with regard to playing basketball, I am unequal to Larry Bird, even though he has retired. However, before the law, if he and I were in a vehicular collision, there should be no inequity before the law. Being realistic and being from Boston, I am afraid that the court would lean to a Celtic player rather than to a plastic surgeon.

In my opinion, what has happened in America is that the inequalities have come to be perceived by the public as inequities. Physicians really have more medical knowledge than patients. This is because of their long schooling and training and their greater experience. Physicians are expected to know more about disease than are patients. This does not mean that physicians are infallible – far from it. The media strive valiantly to equip patients with ways to make up the difference in knowledge. Readers and viewers receive information, sometimes very specific information, more like a manual of what to ask, what to say, and what to look for when one goes to a doctor, including how to choose a doctor.

The United States, which has always prided itself on being a democracy, has never known what to do with elite groups, ie, people who have special skills because of specialized training and achievement. After all, there are teachers,
nurses, astronauts and lawyers. While the public may delight in the particular talent of a singer or a rugby or baseball player and are willing to pay for that proficiency, they resent having to pay when they must call upon a doctor. Patients become painfully aware of their vulnerability medically and financially.

Patients for centuries have voiced their ambivalence about their physicians. Unlike in China, where physicians were paid by patients only when they were well, most people rely on doctors hopefully to ameliorate illness or, even better, to cure it. Ultimately, of course, the doctor and the patient lose since health declines and death supervenes. How good can medicine be if people continue to die? That type of thinking, simplistic and seldom voiced, is nevertheless commonly held. In our country, these ambivalent feelings are accentuated negatively when patients have to pay for the treatment of a condition for which they do not feel responsible, even if they are: eg, emphysema in a heavy smoker.

Ambrose Bierce, an American writer around the turn of the last century, in his famous Devil's Dictionary, defined the physician as "One upon whom we set our hopes when ill and our dogs when well".

Voltaire once commented that the "art of medicine consists in amusing the patient while nature cures the disease".

Pertinent is the Yiddish saying: "If your time hasn't come, even your doctor can't kill you."

INCOME

The coexistence of gratitude and anger in the patient in his or her relationship with the physician accounts for the public's anger about doctors, especially their income. Newspapers in the United States have recently published figures that indicate that the average income of a physician is about $150,000. Not surprisingly most of these articles neglected to mention that a hard working family doctor has an average income that is less about $111,000. According to other data, the average work week for a physician in the United States is 60 h. One can then calculate that the hourly wage of a family practitioner is less than $36.00 an hour and for all physicians about $55.00. Someone pointed out that his auto mechanic and plumber do almost as well. Usually forgotten is the fact that physicians have typically a debt of about $50,000 when they graduate from medical school and about $85,000 when they complete their residency.

The public may gripe about professional athletes earning a large salary but, as far as I know, they have yet to mount a demonstration of protest outside ball parks. Sickness is not entertainment; one seldom laughs during the performance. The physician, for better or worse, is associated in the minds of most people more with disease and death and less with prevention and cure. Except for the birth of a baby, what joy do most doctors bring into one's life in a professional sense?

My view, admittedly cynical, is that if every voice were heard, if every flower bloomed, if every patient were to think of himself or herself as equal to the physician in knowledge, there would be bedlam.

The social system, ideally, should be like a symphony, hopefully without a tyrannical conductor. During parts of the symphony, the percussionist, for example, may have to remain silent in order to let the strings sound forth. This working together produces pleasing sound, an effective performance and certainly not cacophony.

I believe that in the United States acting in concert rarely happens outside the symphony hall.

Our country is vast but our entitlement, vaster still.

I am reminded of a story about someone being accosted on the street by a man who asked for money for a cup of coffee. He gave the man a quarter but was told that it was not enough. In response to the question of how much he wanted the man replied, "$350".

"$350 for a cup of coffee?"

"Yes, I want to drink it in Brazil," the man retorted.

The American public, I am afraid, still wishes to drink its coffee in Brazil and wants to have coffee of all types: caffeinated, decaffeinated, espresso, cappuccino. Health care in the United States, for those who can afford it, offers an unlimited variety of procedures and is probably the best in the world. However, there will have to be a massive change in expectations, an enormous relearning experience for the public as
well as for physicians if, indeed, costs are to be controlled. Access to care and to specialists will definitely be curtailed.

I am told, for example, that in all of Canada there are fewer than a dozen magnetic resonance imaging (MRI) machines, whereas in New York City alone there are supposedly more than 20. Is the United States right and Canada wrong or vice versa? I certainly do not know, but what I do know is that Americans, while complaining about health care costs, spend on an average day, for example, $434,000,000 on toys, $46,500,000 on beauty-related goods and services, $10,500,000 on potato chips and $3,500,000 on tortilla chips.

Daily, Americans purchase 1.5 billion cigarettes, make 7 million unnecessary photocopies, rent 6.3 million videos, and are bombarded with $3,000,000 worth of beer and liquor advertising, not to mention the many millions of dollars spent in their consumption.

I suppose anything is possible in a country that pays its president $547.00 a day and its entertainers like Michael Jackson $164,383.50 a day and Bill Cosby $95,890.41 a day.

Perhaps I am unfairly critical of my country in expecting it to show sense in its priorities when most other non-subsistent nations behave in the same way, thereby fulfilling Oscar Wilde’s injunction: “Take care of the luxuries; the necessities take care of themselves.” Unfortunately, they do not, at least as far as health care is concerned.

What is needed, of course, is a minimum of common sense and a maximum of self-discipline, admittedly the rarest of today’s virtues. How can a government exhibit these qualities when its citizens lack them? Imagine the outcry of entitlement that would follow a nationally televised speech by the President on this theme replete with some of these figures. Fantasize the near-apoplectic reaction of the millions of beer hounds, shopping mall addicts and sports voyeur’s to the suggestion that they divert to the cost of health care, indeed disease prevention, the money they shell out uncomplainingly on inanities. By this time in the President’s speech, irate viewers would have hurled their beer cans at the TV screen and the President would not only have lost the next election, perhaps even the nomination, but impeachment proceedings would already have begun. Suppose he were sufficiently daring and foolish to go further and to recommend that Americans voluntarily refrain from dining out for three days a year, thereby saving about a half billion dollars. The President, if he still had the microphone and it had not been snatched away by a fearful aide, could remind Americans that 37 million of our citizens lack health care while, on an average day, 145,000 cats and 218,000 dogs visit their veterinarian and 68 animals are even treated with acupuncture!

Obviously a man or woman who would give this kind of talk would never become President. Such a candidate would have been eliminated (and I mean eliminated) at the starting line (2).

An unfortunate sequela of the health care scene, in my opinion, is the present war against specialization and specialists. While it is true that we need more generalists – pediatricians, family practitioners and internists – I do not believe that we should settle for fewer specialists. If, indeed, 37 million more Americans come into the mainstream of health care, then we will need more specialists, not fewer. It is easy to tell someone else to be content with a generalist, and I have nothing against family doctors obviously. But it is not easy for someone to take his or her own advice.

While we may object to the fragmentation of medicine, I do not consider it a curse and, in fact, I strongly believe that progress in medicine was made by specialization, just as progress in any field – teaching, law, economics, baseball, cooking – occurs when people think more and more about less and less. This does not necessarily make a fine physician but it can account for many of the advances that we have experienced in medicine: from vaccines to microsurgery to endoscopy and to safer methods of anesthesia.

The paradox is that President Clinton’s experts are saying that we do not need experts. He might even make the statement: “My experts say that I do not need you experts.”

I expect that our government is likely to be quite punitive in this situation; giving less money to medical schools and hospitals for training specialists. The number of specialists will decrease. I remember very clearly the move by the United States many years ago to reduce the number of PhDs in science – until Sputnik appeared and then there was a scramble to catch up.

So here we are today, all in life’s caldron: physicians and patients, all human beings, all subject to the law of decay. Certainly one would hope that we could pull together but it is going to take a while before this is to happen, certainly in the United States.

The physician, whatever his or her limitations, is still the person that most people will call when they are ill. Health care administrators do not get emergency calls about dying human beings; they do not have to rouze themselves out of bed at 3:00 am. Those who pass medical legislation have different standards of care for themselves and their families than for their constituents.

As someone active in teaching medical students and residents, and as someone who listens to what is happening in the surgeons’ lounge, I can tell you that there is an unfortunately disproportionate amount of energy going into fear of the future. In the United States we spend a tremendous amount of energy getting ready to treat somebody, or obtaining permission to do so, and less and less time in the actual act of doctoring for which most of us went into medicine.

In conclusion, I would offer only one observation that I unfortunately cannot claim as my own: “If you can keep your head when all about you are losing theirs, you’ll at least be taller.”

REFERENCES