BETTER DOCTOR TRAINING, WORSE PATIENT CARE

by Samuel Shem (11/25/03)

Twenty-five years ago I published *The House of God*, a novel of my medical internship. It described a brutal, authoritarian system of training that dehumanized doctors and patients alike. Since then I have spoken with medical students and doctors at almost every medical school in America, and have observed the historical movement of the training process. The irony is that as medical training has gotten better, patient care has gotten worse.

Medical students now are better prepared. Many schools require 'externships', where the student functions as a first year resident. Some schools, like North Dakota, require that much of the student's final year is spent in a clinical practice with a senior doctor. Students now are more worldly—they might have worked in a Cambodian refugee camp, an AIDs clinic in South Africa, or done rural health in Haiti. Given the fall in doctors' income and status, they are not going into medicine for the money or the prestige.

The training system is becoming more human. Traditionally it was run with all the subtlety and humanism of the military—a 'power-over' system

where your rank gives you power over the next doctor down. This led to cruelty and frank abuse, where the lower-downs got isolated from each other and from their authentic experience of the system itself. You start to think "I'm crazy for thinking it's crazy." Now the system is somewhat more 'power-with,' emphasizing dialogue and mutual decision-making. The recent cap on on-call hours is a great improvement. In the past, your doctor was so sleep-deprived that he might be seeing double and mistaking a heart murmur for a bowel rumble. The recent limit of hours to 80 a week is progress.

There have been other humanizing forces. Now 50% of residents are women, who, as carriers of relationship in our culture, try to bring these priorities into medicine. Residents now get instruction in ethics, especially around the terminally ill. Emphasis is shifting from knowledge to understanding—with Palm pilots in our pockets, there is an opportunity to shift from the clutter of information to the crux of understanding. Residents may now have time to think—or, better, connect with patients and with each other. Isn't that what we want? A doctor with the data at his or her fingertips, and an ability to understand, to "be with us" empathically? Our new doctors are of that breed.

Why have these improvements in doctors' training not significantly impacted the overall care of patients? Three recent examples:

A pregnant woman goes into premature labor and is bounced around from one emergency room to another until she starts hemorrhaging and is admitted, comatose.

A young woman faints in the heat and is brought to a large city hospital where the resident does enough bloodtests to exsanguinate a puppy and gets a CAT scan—all because of the hospital policy to practice 'defensive medicine' and avoid lawsuit.

An alcoholic, at the end of his three days of insurance coverage in Boston, tells the claims person—a teenager in Topeka—that he's afraid to leave, and asks "What am I gonna do?" "Go out and get drunk," she says, "and we'll readmit you for another three."

These three examples reflect the larger picture. None of these are cost-efficient, or examples of good care. Preventive care is not valued (outpatient doctors routinely spend about nine minutes per patient visit; things are routinely missed.) Hospitals are less available—in the past several years approximately 1000 hospitals (of a total of 6000) closed their doors. The ones still in business are overwhelmed, cutting costs. Because of cost cutting and insurance industry pressure, the time a

resident can spend per visit with any one patient is severely limited. The hospital stay is dangerously foreshortened, so that the resident never really gets to know the patient well, never gets to use these new humanistic skills. Paperwork and defensive tests consume the resident—about 25% of the $1.66 trillion dollar per year health budget goes to administrative costs—$399.4 billion dollars a year for pushing paper instead of patient care. Because of all this, mistakes are rising: your chance of being a victim of a mistake during your hospital stay is over 50%.

The reason that doctors can't provide patients good health care is that the American health care system prevents it. It gets between the doctor and the patient like a wrong pair of glasses. Doctors can't give the care they aspire to; patients feel the limited care.

Health care in America is a national disgrace. Many doctors my age are leaving medicine; many patients are appropriately irate. A national disgrace demands a national solution. Change will not come from the private sector. Insurance executives, after all, are the oil men of medicine. Only when things got really bad in medical training did we doctors act. The cap on on-call hours came from the combined pressure brought by patients (the Libby Zion case) and doctors (the residents

forming unions). We doctors need to organize and resist—perhaps announce an intent to strike, a year from today, unless there is a plan for a national system in place—to revolutionize health care as we have tried to humanize our profession. America can afford it. It's a matter of priorities (start by taking a nibble out of the annual $401.3 billion military budget), efficiency (nationalizing could reclaim about $325 billion annually of the $399.4 billion spent on 'paperwork'), and finding a leader who understands that "compassionate" health care is more than just a sound bite. The administration's war on Medicare ("we had to destroy it to save it") is a cynical election year ploy, a slip down the slope to privatization and profiteeering. Ironically, one of the few issues that Bush/Cheney has not misled the American people about is an overall health care plan—it has none.

Samuel Shem (pen-name of Steve Bergman, M.D., Ph.D.) is author of the novels THE HOUSE OF GOD, the 25th anniversary edition published this year, and MOUNT MISERY.