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Medicine and society

What society and medicine want—for themselves and from each other

by Frederic W. Hafferty, PhD

I will not pretend to grapple here with the full range of balance and self-identity issues posed to me by *Virtual Mentor* for this essay. Those questions concerned the growing gap between what society has always expected of the medical profession—that doctors be available whenever needed and give priority to the interests of the patients in front of them at all times—and the expectations of medical students and new doctors—to have rich and balanced lives outside of the profession and to balance the health needs of the public with those of the patient in front of them. Can—or *how* can—these two sets of expectations be met? I believe these questions are as foundational to the overall health care debate as issues of cost, quality and health disparities.

Is there a gap between what society expects and what physicians want to provide? Yes. Is this gap growing? I am not sure. Social groups have a tendency to mythologize the past, and it is not altogether clear that the public-of-old expected doctors to "be available whenever needed" and to “place the interests of patients first”—regardless. What *is* clear is that the nature of the patient-physician relationship has changed. When my father and uncle practiced medicine, physicians made house calls and held “office hours” in their own homes. Before my uncle (who lived across the street) built a small three-room office annex, patients waited in the living room, attended by my aunt. Physicians lived in the same neighborhood as their patients or "just down the street.” Patients and physicians really did know each other—for better and for worse. Many of my father's patients knew he drank too much (he was an alcoholic), but they also embraced his commitments to them and to the community. Did this intimacy of caring and knowing generate expectations? Yes. Were they boundless? No. Patients respected the fact that my father and uncle each had a “private life.” There were evening calls (my mom screened them), but I know there could have been more.

Nonetheless, my father and uncle were absentee fathers. My father rose at 5:30 a.m. and came home (when I was younger) long after I had gone to bed. After all, he had evening office hours Monday, Tuesday, Thursday and Friday. My uncle chaired our town's school committee and recreation board for decades. Tangible family prices were paid for their involvements with work and community.

I would also be less than forthcoming, this time as a sociologist, if I did not point out that people today *are* less connected within their communities (think Robert D.

Putnam's *Bowling Alone*) [1], less connected with each other (the typical American adult identifies himself or herself as having two friends) and overly connected (at least within certain segments of our society) with the lives of their children (reflected in the negative characterization of today's mothers and fathers as "helicopter parents").

Are there patients today who harbor inappropriate expectations of physicians? Of course. They existed in my father's and uncle's day and they will exist tomorrow. There is, however, another facet to this story—that of *appropriate* expectations. What does society have a *right t*o expect, from medicine and their physicians? And what about the gap between these rightful expectations and what the profession delivers?

One rightful expectation is quality health care. The February 2007 *Consumer Reports* contains a national survey ("Get Better Care from Your Doctor") examining the patient-physician relationship [2]. For physicians, the number one complaint (shared by 59 percent of physicians) was that patients "don't follow their prescribed treatment" [3]. Yet, we know both from news accounts of medical mistakes and from quality-of-care studies published in national medical journals, that the actual delivery of appropriate health services can be a fairly iffy proposition.

We know that conflicts of interest riddle clinical medicine and clinical research, and we know that physicians can and sometimes do cause patients harm. We know that members of minority groups trust physicians less than those in the majority do—just as we know that disparity in health care is a national scandal and that African Americans and other marginalized populations have been the object of abusive research practices by medical researchers. (See, for example, the recently published *Medical Apartheid* by Harriet Washington) [4].

Finally, we know that low health literacy is a major impediment to good health care (90 million Americans are unable to "adequately understand basic health information") [5], that there are significant communication pitfalls between physicians and patients, and that many patients genuinely are confused by their physician's directives (including how many pills to take when the doctor says, "Take two tablets by mouth twice daily"). Each of these discords is a serious gap.

At the same time, we know that physicians are worried about the future of medicine as a profession—including the pivotal issue of practice autonomy. Good medicine, physicians insist, requires that they have considerable discretion in clinical decision making. *Authentic* and effective discretionary decision making, however, requires a foundation of requisite skills, knowledge and values, along with the demand-sided need for their deployment. Do all physicians possess the necessary abilities to appropriately differentiate between the usual and the genuinely unusual? Unfortunately not. On one side of this gap is uncertainty—the incompleteness of scientific knowledge. After all, we are just beginning to compile the kinds of evidence necessary to practice truly scientific medicine. On the other side of this gap,

however, reside physicians who cannot or will not provide their patients with standards of care well-accepted within the profession. This, too, is "discretionary decision making."

So, how do physicians plan to practice quality health care? One answer—one of many, I hasten to add—is that they expect to practice medicine less, which is not the same thing as "practicing less medicine." Today, in my community, a full-time practice is four days a week—and quickly moving toward three. These cutbacks in time-at-work are driven, in part, by issues of lifestyle and the desire to achieve a more satisfying balance between work, family and personal responsibilities. This past month, I spoke to a physician friend who is moving from one practice community to another and taking a position with a clinic that serves the poor and disenfranchised. He has negotiated to work 3.5 days a week. A senior physician friend recently retired. His partners found they needed to hire two physicians—a physician and a nurse practitioner, actually—to cover his workload. The schism here is not patient-physician or society-medicine, but rather generational. Perhaps, given today's advances in biomedicine, a physician need not work the hours my father and uncle worked to achieve the outcomes they achieved—or better ones.

But, is wholesale cutting back a solution? I wonder. One reservation has to do with the nature of medical work and the amount of time rank-and-file physicians need to commit to that work to achieve and maintain excellence. About 15 years ago, during the first few years of the physician-executive movement, a few physician friends began to take on administrative responsibilities with defined splits (90/10; 80/20; 60/40, etc.) between their bureaucratic and clinical commitments. The realization that they were planning to practice medicine on a less-than-full-time basis came, frankly, as a shock. Can one practice good medicine "on the side"?

Do I begrudge medical students and residents their search for balance and more personal and family time? No—to a point. I truly did miss my father. I would have liked to know him better. But there is always a cost; there is always a trade-off. Today's four-hour-a-day physicians, those who take no calls, and those who practice medicine as shift work or on a *locum tenens* basis will not be appreciated by their patients the way my father and uncle were. Their patients will not host dinners to honor them as my father's patients did for him a few short months before he died.

On the upside, some claim that doctors who are less harried and pressed, and who do not conflate their work and personal lives, deliver higher-quality health care. There is, however, no proof supporting these claims, although there is data supporting the converse, that sleep-deprived residents are more prone to make medical mistakes.

One of the great challenges for the professionalism movement in U.S. medicine is not the crafting of new codes and charters, but rather the transformation of an occupational culture that is profoundly antireflective and poor at self-monitoring into one that promotes both self-reflection and self-monitoring. Both deficiencies have to change before the recalibration of work-leisure becomes an accepted part of the

medical landscape. The first-order balance I seek is the balance between work and reflection on that work, the balance between responsibility for one's own work and for the work of peers. Perhaps we can achieve these balances first. Otherwise, less time *at* work is just more time *off* work.

The issue, obviously, is not time (as a Newtonian absolute). It is the socially contextualized nature of time and what we do with it. The newly instituted 80-hour workweek for residents results in more rested residents *only if* they take at least some of the extra time for rest. Otherwise, we have a faux solution to a quite real quality-of-care problem. If physicians are still going to see 35 patients during their workday, or fail to use their out-of-clinic time to stay abreast of current changes in medicine, then we have a problem of quality regardless of how many days off those physicians might enjoy. The key is to prevent physicians' lifestyle preferences from becoming patients' iatrogenic health-style (or death-style) outcomes. There is, after all, a very real threat that what physicians want for themselves has a significant public price, and one many patients may not and *should* not be willing to pay.

Let us worry about the quality-of-care gap first, and then about how many days a week physicians should work (and want to work) to deliver that quality. Once we have calmed the quality-of-care beast we can tackle that more amorphous gap between the public's "unspecified demands" and physicians' expectations for "rich and balanced lives" outside the profession—including whether and how that rich and balanced lifestyle should be paid for by that very same public.

References

1. Putnam RD. *Bowling Alone: The Collapse and Revival of American Community*. New York, NY: Simon & Schuster; 2000.
2. Get better care from your doctor. *Consumer Reports*. 2007;72(2):32-36.
3. *Consumer Reports*, 35.
4. Washington HA. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York, NY: Doubleday; 2006.
5. Brody JE. The importance of knowing what the doctor is talking about. *New York Times*. January 30, 2007: F7. Available at: http://www.nytimes.com/2007/01/30/health/30brody.html?ex=1175227200&en=7b83357c013dc86b&ei=5070. Accessed March 28, 2007.

Frederic W. Hafferty, PhD, is a professor of behavioral sciences at the University of Minnesota Medical School in Minneapolis. He is the author of Into the Valley: Death and the Socialization of Medical Students *(Yale University Press) and, with John McKinlay,* The Changing Medical Profession: An International Perspective *(Oxford University Press), and is currently working on two books, the first (with Brian Castellani) on the sociology of complexity and the second on the hidden curriculum*

in medical education. He is the associate editor of the Journal of Health and Social Behavior *and sits on the Association of American Medical Colleges' Council of Academic Societies.*

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