# This Is Not Your Father's Medical Practice

*Daniel L. Barrow, MD*

As a young boy growing up in rural Illinois, I would be awakened by the sound of the garage door opening and my father's car driving down our driveway. My father is a general practitioner—a ''real doctor'' as my kids say—one of only a handful in the county (Figure 1). He was up because he received a telephone call that night from Mr Penstone or Mrs Zimmerman; perhaps Maise had chest pain or Mildred had a high fever. Dad would have dressed and climbed into his car to make the house call far down a gravel road. I would roll over and go back to sleep, and at dinner that night I would hear some of the story. Greta was in the hospital. Wanda was in labor. Someone had been born. Someone had died.*

I am a physician because my father is a physician (Figure 2). Never, for a single day as a child, did I desire to be anything but a physician. Few days as an adult have been any different.

Although my father and I are both practicing physicians, our careers appear as different as they would have been had we chosen different professions. I work in a large academic medical center surrounded by subspecialized partners, residents, fellows, consultants, technicians, and specialized nurses.

My father graduated from medical school in 1957 and began practice with Dr Tom Bunting on October 27, 1961 (Figure 3). The nearest academic medical center was 100 miles away in St. Louis, Missouri. He is not only a general practitioner but a cardiologist, gynecologist, obstetrician, emergency room physician, urologist, gastroenterologist, pulmonologist, and psychiatrist. Throughout most of my father's career, it was impossible to obtain an arterial blood gas. A radiologist came to town once a week to over-read all the x-rays Dad had interpreted that week. A digitalis level took several days to obtain, so clinical judgment always took precedence over a laboratory result. It is no wonder that throughout their lives when my children were sick, they would come to me and say, ''Daddy, I don't feel good. Call Grandpa Warren.''

Many of the differences in our practices and lives are a result of our primary decisions about specialty. But our medical practices are also different because our country today is different from the one that existed in 1961.

Important events in 1961 included the creation of the Peace Corps by John F. Kennedy. The United States invaded Cuba at the Bay of Pigs that year. Yuri Gagarin of the Soviet Union became the first man in space. East German border guards began construction of the Berlin Wall. The United States began underground nuclear testing, and President Kennedy advised US citizens to build fallout shelters. The Organization of the Petroleum Exporting Countries was formally constituted in 1961, and Alan Sheppard, the first US astronaut, rocketed 116.5 miles up. The top television show in 1961 was ''Mr. Ed.''

By 1985, the year I began my practice, the world had changed noticeably. Major events that year included the sinking of the *Rainbow Warrior* and the seizure of the *Achille Largo*. That year, Columbian terrorists executed 100 people, including 11 judges. Ronald Reagan succeeded in his efforts at tax reform. TWA flight 847 was hijacked, and 1985 was the year the United States became a debtor nation. The top television show was ''The Cosby Show.''

With changes in policy, culture, attitudes. and expectations have come changes in the stature of medicine as a profession in our society.

My father's generation was one among generations of physicians whose competence and judgment were assumed and not questioned. From the genesis of modern medicine in the early 20th century, a nearly mythic image of the medical profession emerged, an image of an altruistic enterprise committed by moral purpose and technical competence to patient welfare.[1,2]

The medical sociologist Elliot Freidson, in his monograph *Profession of Medicine*, defined a profession as a group that reserves the right to judge the quality of its own work.[3] Society cedes that right to the professional because of 3 assumptions: the assumption of expertise, that the professional has technical knowledge not accessible to the layperson; the assumption of altruism, that the professional will place the interests of those served above self-interest; and the assumption of self-scrutiny, that professionals will regulate each other without the need for outside interference.[3,4]

My father is not just a very good doctor—he is that—but in a small town he was also privileged. He was privileged to enter the secret and personal places in people's lives, the people of our community.[4] Decades before the passage of HIPAA, he shared secrets with our people. He knew—we did

*Adapted from Berwick DM. The epitaph of profession. *Br J Gen Pract*. 2009;59(559):128-131.

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**FIGURE 1.** My father, Dr Warren Barrow. He was one of a handful of general practitioners in the rural community of Pittsfield, Illinois.

not—that my schoolteacher had a recurrence of her cancer. He knew—we did not—that her son was using drugs. He also began his practice with the privilege of managing all aspects without any outside interference. In my career, medicine has received a wakeup call, and the time-honored definition of profession has been shattered. That wakeup call has come from a variety of critics, including a more informed public, the professional liability industry, government bureaucracies, unions, and even medical organizations with specific agendas.

Remember that definition of profession? The assumption of expertise. Throughout most of my father's career, this was a ubiquitous assumption. Generations of physicians like

**FIGURE 2.** I am a physician because my father is a physician. Top left, my father during his residency. Top right and bottom left, my father with me as a child. Bottom right, a photo of me as a physician.

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**FIGURE 3.** Drs Bunting and Barrow and their announcement of the opening of their practice in 1961.

my father devoted themselves to lifelong learning so that they might earn the assumption of expertise by their patients. At 81 years of age, my father still practices medicine full-time and attends conferences, and his reading table is piled high with medical journals (Figure 4). Through the early part of his career, physicians took a paternalistic approach to patients. This may have been appropriate in an era when treatment options were limited and patients were passive and poorly informed about medical matters. In my career, patients have access to enormous amounts of medical information from the Internet and the direct advertising of prescription drugs to the public. A well-informed patient can be a blessing, but much of the available information is incomplete or often frankly misleading.

And what happened to the assumption of altruism? In 1975, the Federal Trade Commission charged the medical profession with being an anticompetitive monopoly, hastening

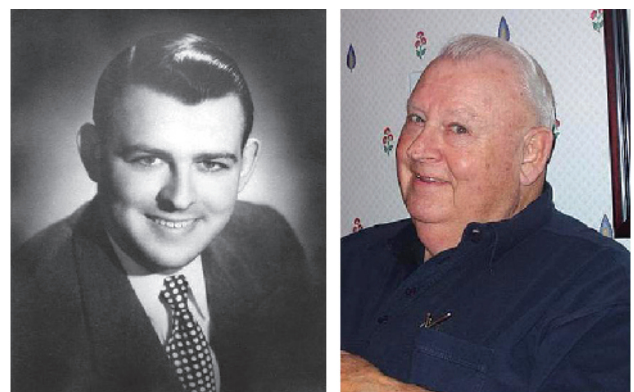

**FIGURE 4.** Left, Warren Barrow as a young physician. Right, Dr Barrow as an 81-year-old practicing physician.

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the transformation of the medical profession from a powerful guild to a competitive business.[2,5]

We are accused of performing unnecessary procedures and diagnostic tests. The reason may be a simple averaging artifact, but it is blamed on physician choice and financial incentive.[2,6] Dad, you would have never known that Dr Bunting ordered x-rays 3 times as often as you did. Dr Bunting did not know either. ''Now you both know, or can know, and so can the insurance company that pays you. And frankly, so can the newspapers. Your private workspace is now flooded with glaring light.''[4]

I will tell you what altruism is: My father was on call every other day for over 40 years and was responsible for all levels of emergencies. I remember one Memorial Day when he made 26 trips to the emergency room, sometimes seeing 2 or 3 patients each trip. He had trained for this. As a resident in internal medicine, he was also on call every other night. Since the Libby Zion case in 1984, the medical profession and the public have been preoccupied with the subject of residents' work hours. Once unthinkable, a new era in postgraduate medical education began in July 2003 with implementation of the 80-hour workweek.[7,8] There *is* evidence that sleep-deprived residents are more prone to errors and accidents.[9]

But residents' reduced work hours have not been demonstrated to have a positive effect on quality and safety.[8,10-12] One explanation is that errors occur when systems designed to enhance patient safety fail, and fatigue among residents does not have an overriding impact. Another explanation is that reduced work hours lead to an increase in the number of handoffs, and this outweighs the potential benefits of reducing residents' fatigue.[13]

In 2008, a committee of the Institute of Medicine (IOM) proposed further reductions to duty hour limits.[9] The IOM recommendations were generated by a committee that included no active surgeons, 1 program director, and only 2 active clinicians. The IOM committee listened to 15 minutes of presentation by 2 surgical specialties, including neurosurgery. In contrast, the Accreditation Council for Graduate Medical Education (ACGME) response to the IOM report was created by a task force that included 16 members made up of 13 program directors, 3 active surgeons, 15 active clinicians, and 1 public representative. Dr Ralph Dacey is one of the members of that task force, which considered extensive testimony from dozens of experts and stakeholders in an effort to address patient safety as opposed to focusing solely on sleep and residency duty hours.[14]

In September 2010, the Occupational Safety and Health Administration was petitioned to intervene and place federal restrictions on resident duty hours. The petition was from, among others, the Service Employees International Union. From the original congressional request for the IOM study, this issue has been fostered by that union. When the ACGME showed some spine and did not cave in, they simply changed tactics. This is about power and an opportunity to organize more medical professionals.

It is clear that an effort to improve the quality of patient care involves a number of competing goods. It is good to have a well-rested physician. But it is also good to have a physician who is trained to put the patient's needs above his or her own needs. The creation of a medical workforce with a shift worker mentality is unlikely to improve quality. We have ''a moral responsibility to prepare residents to practice medicine outside the learning environment, where they will be unsupervised, must think independently, and must function when fatigued.''[14,15]

And remember that other definition of a profession: reserving to itself the right to judge the quality of its own work? That is over. My father, every day, assumed the right to judge the quality of his own work. He was a harsh judge, harshest of all to himself.[3,4] Now we are accused of carelessness. The 1999 IOM report *To Err is Human* charged that there are 44 000 to 98 000 deaths per year caused by adverse hospital events. We are apportioned a share of the blame. The numbers are extrapolations from 25-year-old hospital data, but they are a permanent part of the public record.[16,17]

J. Michael McGinnis, a senior scholar at the IOM, has estimated that the biggest contributor to early deaths is behavior.[18] Today, the greatest American public health problem is obesity. People in their 50s are about 20 pounds heavier on average than 50-somethings were in the late 1970s. This extra weight has caused a significant increase in chronic diseases like diabetes that are unusually costly.[18]

As an intern, my father paid $100 a year for malpractice insurance, and his premiums on starting practice were about $1000 a year. Remarkably, he has never been sued throughout his 50 years of practice. We now have a professional liability industry led by a surplus of plaintiff's attorneys who believe they are capable of determining the quality of our care. ''The United States has 70% of the world's lawyers, but only 5% of the world's population. US law schools produce more graduates than medical, dental and veterinary schools combined. The US has 30 times more lawsuits than Japan, one of America's primary trade competitors.''[19]

''The cost burden of medical malpractice lawsuits is generally assumed to be astronomical. Is it? In reality the numbers are hard to pin down.''[20] A recent study estimates the annual costs of the medical liability system to be $55.6 billion, or 2.4% of all healthcare spending.[21] If accurate, that accounts for a small share of US healthcare spending. But in a country that spends $2.3 trillion on healthcare, that is still a lot of money.[20] Medical malpractice occurs, and its victims deserve appropriate compensation. But victims and plaintiff's attorneys do not need to become rich from the system. No health reform is serious about reducing costs unless it reduces the costs of frivolous lawsuits.

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The intrusion by bureaucracies came after my father began practice and was largely stimulated by the rapid rise in the cost of medicine, for which doctors have been assigned much of the blame. There is no debate over the fact that healthcare costs have skyrocketed, but there is legitimate debate over the real reasons and the real solutions.

When my father entered practice, the costs of health care were relatively low because there was little doctors could do for a large percentage of patients. A physical examination, simple blood tests, and x-rays of the chest, bowel, and bone could identify a few treatable disorders (Figure 5). Many other afflictions readily controlled by modern medicine led to incapacitation and early mortality in those days.[22] My father had the fee schedule shown in Figure 6 before the passage of the Medicare act. During the Reagan years, he was actually forced to raise his fees because they were lower than Medicare and the government would not allow physicians to charge private patients more than they charged their Medicare patients.

My career began with access to enormous technology and options that were previously unavailable and unimaginable. Our country has been remarkably prolific in the development of new diagnostic tools, imaging studies, drugs, and procedures—and remarkably undisciplined in their deployment.[23] ''New diagnostic and therapeutic procedures and the more liberal application of established ones account for two-thirds of the growth in health care expenditures.''[23,24]

During my father's career, the greatest social change was Medicare in 1965 (Figure 7). Like most out-of-control government programs, Medicare began with the best of intentions. It was designed to assist senior citizens with medical expenses. There were legitimate and necessary indications for government intervention and deficit spending. Both were instrumental in thwarting the spread of radical fascism and eliminating the heinous genocide of World War II. Government intervention was crucial in putting a man on the moon and in accelerating the achievement of civil rights. Deficit spending was necessary to end the Cold War. These and other great achievements notwithstanding, most government takeovers rapidly spin out of control.

In 2009, Bernard Madoff was sentenced for what was said to be history's largest Ponzi scheme. In fact, the largest Ponzi schemes in our history were promulgated by Franklin Roosevelt and Lyndon Johnson with the help of their respective Congresses (Figure 8). Social Security and Medicare were sold to the American public as insurance policies that would maintain trust funds for future obligations. That never happened. Medicare parts A and B have combined

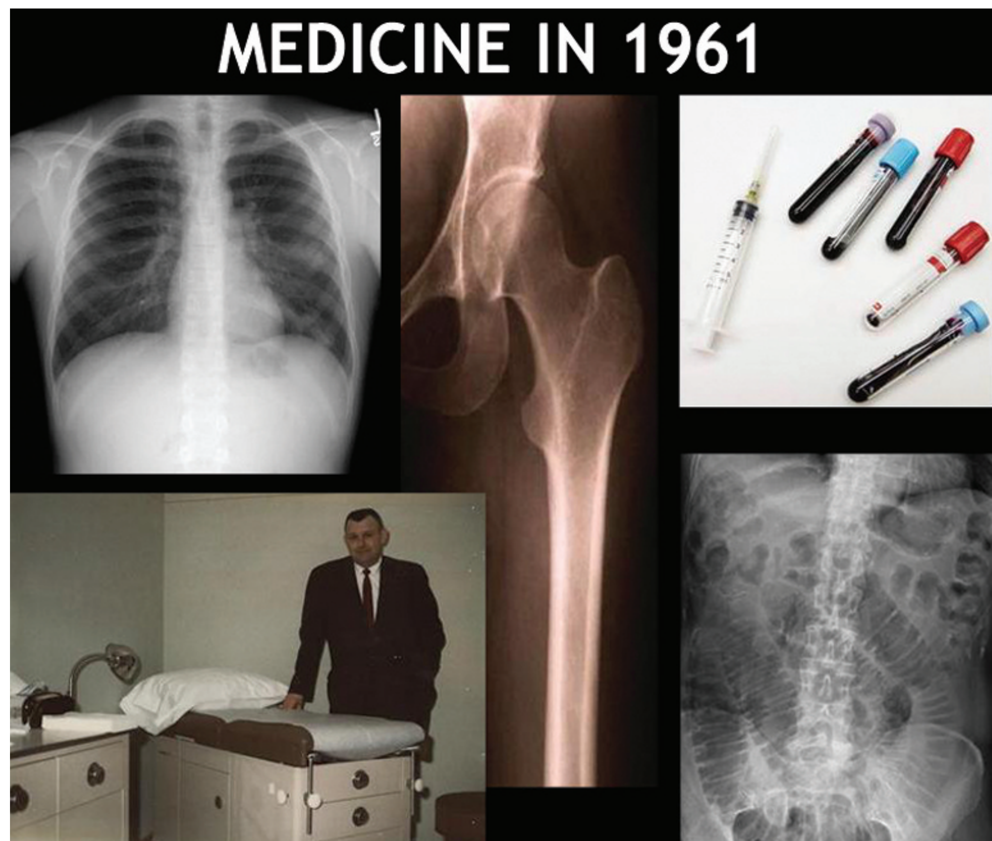


**FIGURE 5.** Medicine in 1961 when there was little physicians could do for many afflictions readily treated today. They could do a physical examination, simple blood tests, and x-rays of the bone, bowel, and chest.


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These charges do not include medicines dispensed by the particular physician or fees for laboratory procedures performed at the doctor's office.

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| | |
|---|---|
| OFFICE CALL | $4.00 |
| HOUSE CALL | 6.00 |
| NIGHT CALL (9 PM to 7AM next day) | 8.00 |
| PRE-SCHOOL EXAMINATION | 2.00 |
| SCHOOL EXAMINATION | 2.00 |
| ALL IMMUNIZATIONS (per injection) | 2.00 |
| MILEAGE: | |
| ON PAVEMENT | 50c per mile |
| ON GRAVEL | 75c per mile |

**FIGURE 6.** My father's fee schedule early in his practice. During the Reagan administration, he was required to raise his fees because physicians were not allowed to charge their private patients less than Medicare.

unfunded liabilities of $68 trillion. Despite knowing that Medicare was hemorrhaging, George W. Bush and Congress passed the Medicare Prescription Drug, Improvement and Modernization Act in 2003, which authorized Medicare to cover prescription drug costs starting in 2006 (Figure 9). In less than 3 years, that act had run up additional unfunded liabilities of $17.2 trillion.[25] As pointed out by Glenn Beck in his book *Common Sense*,

■ David Walker, the former comptroller general of the United States [meaning he was formally in charge of keeping our government's ''books''] called Medicare Part D, 'probably the most fiscally irresponsible piece of legislation since the 1960s…because we promise way more than we can afford to keep.' For anyone keeping track, our politicians have committed future generations to pay a combined $99.2 trillion just for unfunded Social Security and Medicare obligations. Add in our national debt and interest payments and you'll easily exceed the capability of most calculators.[25]

Dad, if you think Medicare was an intrusion, put on your seatbelt. Mr Walker made that assessment before our current administration passed the Affordable Care Act of 2010 by House and Senate reconciliation (Figure 10).

We are accused of placing our interests above the interests of those we serve because of conflicts of interests. Indeed, there are examples of physicians whose relationships with industry or pharma have led to egregious acts of conflict out of self-interest. In an attempt to thwart these isolated incidents, the conflict-of-interest zealots are threatening to destroy the highly beneficial relationships among physicians, industry, and pharma that have been the basis for some of the most important medical advances the world has known.[26-28] Medical research will be useless if it does not ultimately lead to the development of a product that helps the lives of humans.

**FIGURE 7.** The greatest social change in medicine during my father's career was the passage of Medicare in 1965.

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**FIGURE 8.** The greatest Ponzi schemes in our history. Right, the passage of Social Security by Franklin Roosevelt. Left, the passage of Medicare by Lyndon Johnson.

In his isolated community, my father developed professional relationships with drug company representatives who would assist in educating him about new pharmaceuticals. He had the educational background and professional attributes necessary to make rational decisions about the proper use of those pharmaceuticals. Today, in my own institution, I could be accused of a conflict of interest for possessing a ballpoint pen bearing an Anspach logo. What is the concern? Is there a fear I will perform an unnecessary craniotomy? Drill an excessive number of burr holes?

I support the requirement of disclosure of true conflicts of interest by speakers at continuing medical education functions such as this. But the pendulum has swung too far. Most of you are probably unaware of the fact that all of the 700+ presentations that will be delivered at this meeting had to be reviewed, slide by slide, by volunteer members of the CNS Executive Committee 2 months ago. Next year, the ACGME will require not only that review but also a second review within 48 hours of the presentations.

Has professionalism in medicine been tarnished by the criticism of self-appointed critics and by bureaucratic

**FIGURE 9.** Knowing Medicare was hemorrhaging, George W. Bush and Congress passed the Medicare Drug Act.

**FIGURE 10.** President Obama signing the Affordable Care Act of 2010.



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intrusion? Some in our profession believe these changes threaten the values of professionalism.[29] Like Laurence McCullough, who has written extensively on the subject of medical professionalism, I believe these folks have made the wrong diagnosis.[15] It is

■ that physicians' free and un-coerced decisions in response to changes in the organization and financing of medical care threaten medical professionalism. The profession of medicine is not a given that comes down to us robustly from the pen of Hippocrates. Rather, the profession of medicine exists as a function of the collective clinical judgments, decisions and behaviors of physicians. External entities such as government and payers do not create the profession of medicine and they cannot destroy or injure it.[15]

We are not witnessing the epitaph of our profession, but we are certainly witnessing its evolution. Biological evolution makes missteps, and so can social evolution. Most of these bureaucratic intrusions began as well-intentioned efforts that place competing goods at odds with one another. I believe the pendulum has swung too far in our efforts to recalibrate the compass. Despite the dramatic changes our society and country have witnessed in the past 50 years, my father has remained regal in his community, has adhered to the principles of professionalism, and has demonstrated a remarkable ability to adapt to this changing environment.

Perhaps this *is* my father's medical practice. He has been the compass for my career, and I pray I have lived up to the standard he set (Figure 11). My daughter began medical school this year, and I hope to be a compass for her career.

Medicine was a noble profession before these intrusions and will remain noble through criticism directed at its practitioners. We may not like the criticism, but, as James Jackson said in his timeless 1855 publication, *Letters to a Young Physician*: ''I have often remarked that, though a physician is sometimes blamed very unjustly, it is quite as common for him to get more credit than he is fairly entitled to, so that he has not, on the whole, any right to complain.''[30]

**FIGURE 11.** My father has been the compass for my career, and I hope I have lived up to his expectations.

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## Disclosure

The author has no personal financial or institutional interest in any of the drugs, materials, or devices described in this article.

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