The Pickering Report, Part IV: the social changes that confront today's physician

By Edward A. Pickering

In Part IV of his report, Mr. Pickering concludes his assessment of public response to the medical profession and addresses himself to the problems inherent in new social attitudes toward health care delivery.

Substantial representations were received from associations representing the hospitals of Ontario and the organizations of allied health workers.

There is no evidence of any desire on the part of these organizations to place themselves in a position of conflict with the medical profession. Nevertheless, there are many grave problems — some of them no doubt highly controversial in nature — which confront these health communities in their relations with the medical profession.

The brief of the Ontario Hospital Association touched upon some of the sensitive aspects of their relationship as follows:

> The continued self-government of physicians within the community hospital structure must depend upon the conscientiousness and integrity with which the necessary committee and officer responsibilities are undertaken. The most capable and responsible persons must be chiefs of staff and heads of departments. It is not unknown for these positions to be filled by doctors who depend on referrals from their colleagues for their practice and are therefore susceptible to pressure if they attempt disciplinary measures.
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> The association believes that a contracted salary arrangement is both feasible and desirable for medical specialists who practise exclusively, or almost exclusively, in the hospital setting, such as pathologists, radiologists, some surgeons, emergency care specialists and staff psychiatrists.
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> We believe that, if the fee-for-service concept is to be retained, the tariff should be negotiated between the Ontario Medical Association and the Ministry of Health, with direct OHA participation regarding fees which will have significant effect on hospital budgets. We further believe that any future fee tariff should be transformed from simply a method of reimbursement into a positive instrument for influencing where medical care is provided.

The hospital organizations agree that the hard core of professional decisions must remain with the individual physician subject to peer review and control. The growing complaint from hospital administrators is that peers are prone not to exercise this control over their colleagues and that consequently doctors are seldom called to account by their peers.

The Ontario Medical and the Ontario Hospital Associations are currently engaged in a joint study of district health councils. It is to be hoped that these two organizations will recognize the need for extending consultative procedures with the avowed purpose of finding accommodation to the problems arising out of the interrelationship of the doctor and the hospital.

More and more of the practice of medicine is taking place within the hospital setting. The hospitals themselves are under severe pressure to achieve major economies. These circumstances make it all the more desirable that these two highly interdependent communities avoid conditions which might create serious discord in their relationship.

Consulting paramedical groups

As far back as 1967, the Ontario Medical Association took the initiative in establishing a conference on cooperation in the provision of health services. Among other objectives were arrangements "in which physicians share the provision of health services with many other disciplines (allied health workers)." Ways and means of enlarging the use of paramedical services have been examined in annual conferences since that time.

During the public hearings, representations were made by some of the organizations which have participated in these conferences, representing allied health workers — the nursing profession, physiotherapy, occupational therapy, social workers, nutritionists, pharmacists and others. The general tenor of these representations is that the paramedical groups must now be given a wider role in providing a full program of health care — at the same time freeing the physician for the more critical and specialized services which he alone can perform.

Throughout these representations, there was recognition of some progress being made in defining functions which could be properly assigned to the paramedical services. But there were also unmistakable signs of frustration with the slow rate of progress and with the apparent insistence of physicians that they should be, in most if not all situations, the exclusive authority.

There were strong indications in the public hearings and also in the public opinion survey (82%) that patients would welcome greater use of paramedical services.

There are, of course, many matters of substance to be settled before a greatly enlarged use of paramedical services can be achieved. These include training in specific areas, a definition of the assignments which can properly be entrusted to these new services,

statutory definitions of legal liability in certain cases and, perhaps most important of all, a revised basis of compensation, the latter two matters requiring government action.

The related health occupations are the traditional and natural colleagues of the medical profession. In the rapidly changing world of health care, new organizations and new forms are struggling to be born and find their rightful place in the scheme of things. The doctors of this province would do well to satisfy the allied health groups that they understand changes are not only inevitable but are much more urgently required today than when discussions commenced several years ago. If the doctors will also recognize that their own role must, in some situations, be less authoritarian and absolute than in the past, they will have gone a long way towards making this process of change an orderly and helpful one.

The Ontario Medical Association, having as long ago as 1967 accepted the principle that there should be a broader role for qualified paramedical personnel, should intensify and accelerate its efforts to bring about their greater participation with minimum delay.

I THEREFORE RECOMMEND THAT THE ONTARIO MEDICAL ASSOCIATION INTENSIFY ITS EFFORTS TO ENLARGE THE ROLE OF PARAMEDICAL SERVICES.

Medical schools and the OMA

As the following matters relate to the training of doctors to fill their role in contemporary society, I feel they are appropriate subjects for comment in this report.

There was considerable interest on the part of both doctors and public as to the manner in which the medical schools select candidates, who vastly outnumber the schools' capacity to enroll them. For example, at the University of Western Ontario, 100 were chosen out of 1100 applicants in 1972. The criticism generally made was that the medical schools were guided by academic standing exclusively, or almost so, omitting criteria to determine whether a candidate had the personal, human qualities to practise medicine in the social and community context of today. Also, as one doctor put it, a surgeon requires not only academic ability, but physical and emotional stamina, as well as manual dexterity.

We were told that criteria of this kind are now part of the selection process at McMaster and that other schools are broadening theirs.

Another question, similarly inspired, was whether the curriculum sufficiently stresses the psycho-social aspects of medicine so gravely needed in today's society or continues to weigh it almost entirely on the clinical and pathological phases.

Dr. W. J. Walsh, speaking for the McMaster faculty of medicine, indicated that considerable emphasis is being given to the psycho-social content of their curriculum. McMaster's curriculum, among other matters, deals with the importance of the patient's family and community: the doctor's ability to relate to other individuals, to function as a member of a group engaged in learning, research or health care, as well as the physician's ability to work in a variety of health care settings. Medical students are also given instruction in interviewing techniques. Students from other disciplines — nursing and social work — are also involved. Individuals interviewed vary widely in age and socioeconomic background.

The Council of Faculties of Medicine at the hearing in Ottawa stated that the other medical schools were moving in this direction. The medical curriculum is already crowded and pressures are growing for even more content, but the profession's future lies in equipping itself to deal more effectively with the

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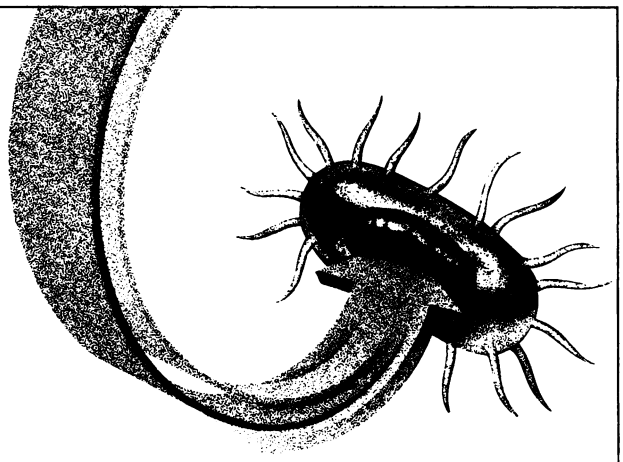

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social, psychological and economic aspects of medicine.

It is recognized that the foregoing matters are specifically the concern of the College of Physicians and Surgeons and of the Council of Faculties of Medicine, not of the Ontario Medical Association. However, in the past the association has made representations with respect to undue reliance on academic qualifications.

I THEREFORE RECOMMEND THAT THE OMA DISCUSS WITH THE COLLEGE OF PHYSICIANS AND SURGEONS AND THE COUNCIL OF THE FACULTIES OF MEDICINE THE DEGREE OF PROGRESS BEING MADE REGARDING BOTH SELECTION CRITERIA AND CURRICULUM CONTENT.

1100 would-be medical students applied for Western's 100 places

Housecalls

For generations medicine in this province has been practised in the main in three locations: in hospitals, in doctors' offices and in patients' homes. The practice of medicine in the home through the medium of the housecall has seriously diminished in our larger communities. Medical equipment cannot be handily transported in the doctor's satchel. With some exceptions, hospitals and laboratories and the doctors' offices alone can provide these services. Because of the distance and time involved in travel in traffic-congested larger cities the housecall creates extreme demands upon a doctor's time.

Notwithstanding these considerations, the general public, as evidenced by both the public opinion survey and the hearings is highly critical of the unwillingness of a large proportion of the profession to make housecalls. Almost 40% of the public taking part in the survey reported their own doctors are unwilling to make housecalls. There are of course doctors who continue to make housecalls even in the large cities, particularly those in group practice.

It is encouraging to note the proposal of the New York General Hospital to organize a limited form of housecall service within its own community. More initiatives of this kind are sorely needed.

The situation in general is serious enough to call for a reexamination of the institution of the housecall; how it can be maintained and in what form and circumstances; and at what reasonable cost.

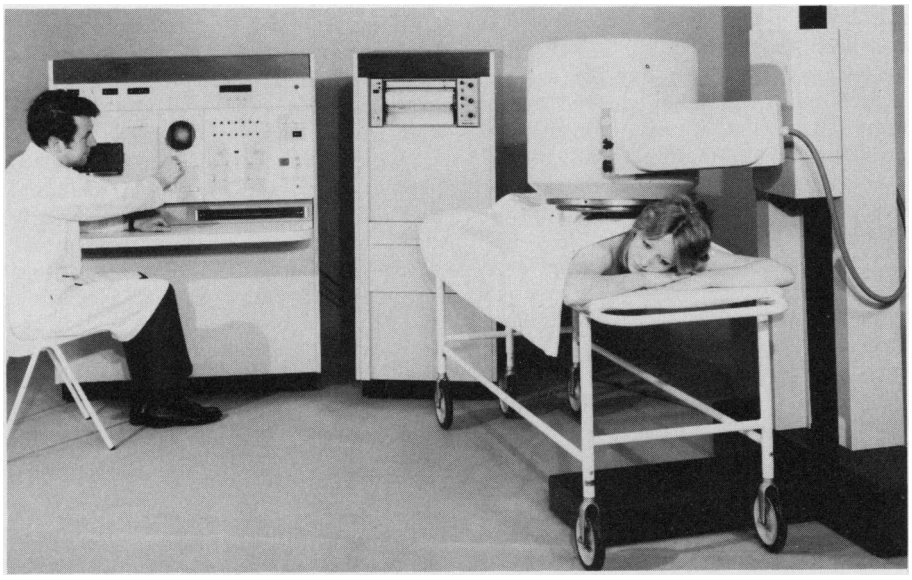
There is urgent need for the profession to provide leadership in qualifying paramedical services to visit patients in their homes for preliminary findings and follow-up treatment. Some form of service in the home is especially necessary for the aged, the incapacitated and mothers with young families for whom visits to the doctors' office or to the emergency department is a hardship, if not an impossibility.

The practice of medicine in the private home has to a substantial degree been shifted to the emergency departments of hospitals which were never designed for this purpose. One can readily calculate that services in doctors' offices are normally available for somewhat less than 25% of the hours in a year, leaving the balance to be cared for in hospitals and more especially in their emergency departments. This has given rise to problems in our hospitals which never existed before. The profession, no doubt unintentionally, has not faced up to the consequences of so immense a change in the way medicine is now being practised. It has perhaps been too busy *with* the practice of medicine to do much *about* the practice of medicine.

There is no simplistic solution for complex questions of this kind. In recent years, one solution was sought by building more and bigger hospitals, some of which in fact may already be outmoded and overbuilt.

Conceivably, we could now embark upon another panacea-type of solution by assuming that all we need to do is to build another string of parallel facilities called community health centres. There no doubt will be a useful place for community health centres in certain communities and under certain conditions, but we would be naïve indeed to look for a total solution through another simplistic approach.

The medical profession should ask itself why the solo form of practice, with some exceptions, prevails so generally in Ontario, while the group or clinical forms have for generations played an important part in the practice of medicine from the Head of the Lakes to the Rocky Mountains. Many



Equipment not handily transportable in doctor's satchel

of the complaints heard frequently during the hearings, such as the fragmentation of medical service and the difficulty of obtaining a doctor at nights and week-ends, appeared less prevalent where group forms of practice prevail. In the public opinion survey, the people of Ontario have registered an overwhelming desire for more in the way of group or clinical practice.

We are not suggesting that there is no place for the solo mode but we do suggest that the doctors of Ontario should seriously review the need for more group and clinical practice.

The public hearings produced convincing and eloquent pleas that the profession should become more involved in the social, psychological and economic consequences of illness and disability. A case was made for rehabilitating disabled patients at home by providing necessary care through visits of doctors, nurses, physiotherapists, dietitians and social workers. Through full or part-time work the patient often becomes a self-supporting tax-paying citizen free of the unhappiness resulting from enforced stays in hospitals for disabled or chronic patients. One of the byproducts claimed for programs of this kind is a major reduction in costs to the state.

A problem standing in the way is the serious shortage of rehabilitation specialists due in part to the low values given to rehabilitation medicine in the fee schedule.

I suggest to the OMA that, in its reexamination of the health care system, it give serious study to the possibilities of home care for the disabled as an alternative to a lifetime of confinement in institutions.

Fragmented medicine

A commonly voiced complaint at the hearings and registered in the public opinion survey is that the practice of medicine has increasingly become fragmented. The patient goes to one doctor, is sent probably on different days for X-rays, laboratory tests and perhaps to a specialist or two. There are frequently long delays between these various steps and frequently there is a long delay before the patient is informed of the overall results if, indeed, she is informed at all. Management of the patient's problem tends to be uncoordinated. The patient often feels she is regarded as a series of symptoms and is not treated as a whole person, but as "another OHIP number". The impersonal attitude of many doctors towards their patients may be due to an excessive workload, but the fact remains that the public is highly critical of the virtual disappearance of the person-to-person element in the practice of medicine.

The fragmentation process tends to scatter the patient's records at a number of points instead of being centrally located in one office. This presents difficulties when the patient requires treatment, particularly under emergency conditions as well as when the patient moves to another city — happening more and more frequently in our mobile society.

These considerations, among others, give rise, we think, to the almost unanimous desire expressed in the public opinion survey for some form of clinical practice.

95% of the public expressed themselves in favour of neighbourhood clinics where doctors from different specialties provide one-stop service. 92% of the doctors in their survey were of the opinion there will be more group practice in the future.

Farseeing initiative

A good example of the OMA's taking the initiative in improving health care in an area otherwise neglected may be seen in the work of its section on ophthalmology.

In 1971 the section cooperated with the Canadian National Institute for the Blind and Lions Clubs in providing Canada's first mobile eye van which was sent to Newfoundland to make eye care available to people remote from such service. In 1972 a second mobile eye van, built with funds donated by the PSI Foundation, was sent to northern Ontario to visit communities where ophthalmology services are not readily available. Ontario ophthalmologists closed their offices and travelled at their own expense to serve in these mobile eye vans.

The section reported that its attempts to provide a more even distribution of eye care services in the province have not been encouraged by OHIP which has been reluctant to pay for services rendered in the mobile eye van on the same basis that it pays for services provided in ophthalmologists' offices.

Reassessment of the health care delivery system would have many objectives.

Sociomedical problems loom large. There is disturbing evidence of unequal standards of care — depending upon economic status, age, place of residence, and ethnic origin — which it should be the goal of an enlightened democratic and Christian society to eliminate.

The psycho-social illnesses which constitute an alarming and increasing proportion of sickness in today's society call for new emphasis.

Mental retardation, hearing and perceptual handicap which afflict the young should receive higher priorities, as should the whole field of mental illness.

Whole new areas, medical in part but social in part, challenge the imagination and resources of our health system as never before.

No one suggests these matters are the sole responsibility of the medical system today. But if doctors remain aloof from a reexamination of the system, a vacuum will be created, and following the laws of nature, that vacuum will rapidly be filled. How much better it would be for all if the doctors of Ontario would recognize that at this juncture they have a unique opportunity to participate in a searching reassessment of this comprehensive and complicated field.

Doctors should be the ones who examine the system and not leave it to planners and administrators who won't have to live with what they create.

On this subject the brief of the Ontario Federation of Labour had this to say:

> Leaders in the medical profession would show great wisdom in giving careful consideration to these changing social concepts and the emerging new patterns that we see about us. We suggest they be the instigators in these changes rather than wait for public pressures to build up in government where somebody else becomes the initiator of these changes.

The profession, however, should realize that it can no longer expect to monopolize a reassessment of this kind. It must be willing to work, in cooperation with other organizations and public authorities, and to provide leadership without seeking to dominate. Its role can no longer be the exclusive and governing one it was in years gone by.

It should also be understood that members of the profession cannot go on doing things in the old familiar ways just because they happen to prefer them. It will be increasingly necessary to help, with others, devise schemes that fit the times and the conditions in which we live, which will serve people where they live and at hours that are reasonably convenient. Nearly every business from stores and movie houses, to banks and service stations, has in recent years changed its locations and hours of business to fit the changing patterns of our times. What the people need is what's important and doctors will have to serve them, within reasonable limits, when and where and how it fits the needs best.

I RECOMMEND TO THE OMA THAT IT REASSESS THE PROFESSION'S RESPONSIBILITIES AND RELATIONS TO THE TOTAL HEALTH CARE DELIVERY SYSTEM. ■