EDITORIAL

The Specialized Clinic and Today's Medical Care Needs

GEORGE A. SILVER

Department of Public Health, Yale University School of Medicine

At one time it was unusual for subjects like "Medical Care Needs," or "Clinic Reorganization" to be dealt with in scientific journals. Professional groups, (internists, pediatricians, surgeons) now give such practical matters a corner of their program and one or two rooms at the conference. The scientific journals follow along.

This is part of the new temper of the times: challenge in social conflict, demands from classes and groups not previously heard from, an earnest search for relevance in professional roles, and, not least, a different division of the spoils. More money is gradually being directed into the service sector of the medical care field, comparatively less into research.

It is almost 5 years since John Gardner stirred the country with his statement on the crisis in the cities and sounded the prophetic note that "the times cry out for change and our institutions resist change with unholy stubbornness." The institutions have begun to search for ways to display concern, give recognition to the crisis while pursuing discreet, dignified ways of avoiding change: no confrontations, of course, and very little change. The medical schools and teaching hospitals have not been totally unresponsive.

In the health field, a great deal is heard about the need for family practice, for revamping medical education. And these are real needs. Yet there is a strange silence about the role of the specialists and their powerful influence on medical education expressed in that major educational tool—the specialized clinic.

The problem of the specialized clinic and the modern management of ambulatory care is an intrinsic part of the problem of inadequacy in the medical care system. Every specialist—or subspecialist—in medical practice has a vested interest in the specialized clinic as it now exists. The specialist knows there is a need for his specialized skill and he is impatient with those who would hamper his efforts to study and treat that need in "his" patients in the way he thinks best.

Despite this skill and the specialist's categorical interest in an important field, it may be that consideration cannot be limited to one aspect of service in meeting medical needs. There is a larger frame of reference, and the interdependency
of medical needs has to be taken into account. In the universe of discourse, everyone is a present or potential patient for a specialist. Everyone is a present or potential sufferer from all the conditions for which all the specialists want separate categorical clinics!

So, in everything that touches medical care of any patient, every specialist is touched. The solution, therefore, must be found in the frame of an overall solution. The specialized clinic cannot exist except as part of a network and ambulatory care cannot exist except as part of a total system of care.

Unfortunately, specialists are not yet prepared to take that global view. Medical professionals have not yet taken the steps to impress the Congress, for example, (either alone or with the lobbying power of their voluntary organizations) on behalf of nutrition, welfare, housing, or equal rights legislation. There have been such strong delegations on behalf of increased appropriations for research institutes and medical schools, though.

On a related tack, how much are these programs judged on their satisfaction to patients? In making plans for the specialized clinics, what do the clients, the patients, the recipients of professional largesse, say?

At the moment it would seem that clinic patients generally are angry and antagonistic to health professionals. This statement does not only include the poor or the minority groups. True, they have much to be angry about, as they are treated like wards, decisions made for them, society—and professionals!—ignoring their hunger, their malnutrition, their decreased life expectancy, their miserable slum lives. Society—and professionals!—concentrating on the damage done our orderly world when the poor break out of their disordered ones, mugging and stealing for money to buy dope or just because it’s easier to make a Hollywood-style life with stolen money than with money earned as bag-boys in the supermarket.

But that’s the poor and the minority groups. Middle-class and even upper income people are angry with health professionals, too. They also think the professionals are greedy and thoughtless and insensitive to their needs. They have to use the emergency room evenings, Wednesday afternoons, and Sundays. And it costs a fortune to be sick. Of course, they do have insurance, but that’s just a down payment on the expensive course of care. Premiums on insurance go up and up and coverage goes down and down. Even the best of American health insurance coverage, Medicare, or the prepaid closed-panel insurance systems like Kaiser Permanente or Health Insurance Plan (HIP) pay only about 40% of the total average cost of health and medical care. Most “health” insurance allows the insured to pay what he would have paid anyway plus the premium. Except for the largest health insurance companies, private commercial carriers have a 50% loss ratio. (That is, they pay out in claims on the patient’s behalf, 50 cents on every dollar they take in in premiums.)

The American health system, private practice and the clinics face a day of reckoning. Consideration of the role of the specialized clinic at this point in modern management of ambulatory care may be too little and may be too late. There is an accumulation of demand for change, whether in the financing mechanisms for paying for medical care, or in the organizational structure—call
it prepaid group practice or Health Maintenance Organization (HMO)—or in both, as in the proposals for National Health Insurance from a wide variety of sources in and out of the Congress, as well as from the present Administration in Washington.

So the poor and the blacks want equity, equal access, equal treatment, an end to waiting lines in clinics, to humiliation and condescension in treatment. The middle income group wants an end to frantic and desperate efforts to reach medical care at critical times and an end to scandalous inflation of cost; and everybody wants a system, a clear plan with an entry point and guides and interpreters along the way, responsible professionals taking charge, accountability in the system.

The irony is that we are all victims now. The conditions of the medical care system which once served the poor badly, serve everyone badly too. Not so badly, perhaps: but certainly not so well as we could be served in the present stage of knowledge and technological development.

America has depended upon the market system—supply and demand—to correct for all the complicated changes in technology and distribution of medical resources. The larger proportion of cost for health services is still met from private sources, with meager public contributions to meet the needs of the poor. Medicine was the beneficiary of scientific and technological development, enlarging its scope, increasing its beneficial effects, multiplying its work force, increasing the cost. People are more aware of the latent benefits of medical care, beyond relief of pain and treatment of illness. Sick and hungry children don’t learn as well, and may be permanently intellectually deprived. Society has little use for the uneducated today. Sick and hungry people can’t be trained for jobs that do exist, and can’t hold them or advance in them. Running a household, raising a family, may be beyond the capacity of a hungry, sick mother.

So, where a system of health services is more urgently needed to offset the lack of education, lack of effective jobs, poverty and hunger, it is less available. The market system has not allowed the manpower and resources to develop or be distributed to meet those needs, and the concept that those who have the money get the services can’t make that care available to all those who need it.

This is not the occasion to enter into a catalogue of the deplorable health status of the urban poor, the rural Americans, or the general health status in this country as compared with a dozen or so other advanced—that is, technically advanced—countries in the world. Nor to enter into statistical debate about whether these numbers are significant, really comparable, or illustrate deprivation of medical care if they are accurate. Most people will agree that the medical care delivery system in this country could stand some improvement, if not outright renovation. The issue is not financing, not organization, not control—the issue is equity.

The bitterness and hostility of the poor and the minorities, and to a lesser extent the anger and hostility of the more affluent majority, against the stubbornly unresponsive medical care system derives to a very great extent from professional attitudes. The doctors don’t really listen, the patient’s have no one to talk to. There is no dialogue, in the fashionable phrase.
Before debating a role for the specialized clinic, one might ask who decided that there ought to be specialized clinics and not some other form of medical service. Wasn’t it designed by the specialists on their professional recommendations? And in their interest? Do the professionals really believe that their patients—the public—fully understand what is at stake and why the specialized clinic is the best option—if it is? Do they know all the ways there are for dealing with the problems of management of heart disease, cancer, or diabetes; all the measures possible for prevention and rehabilitation? And that from that knowledge they have concluded that specialized clinics are the best answer? Who spoke for the constituency of patients? Who made the budgetary decisions? Among the great voluntary organizations—the voice of specialism—that collect from the public to “prevent” or treat, or educate, in the fields of heart disease, cancer, diabetes, genetic defects, how much of community service is still lip service, a comfortable professional response, a Procrustean response in which the lodger is being stretched or having his legs cut off to fit the inn-keeper’s bed?

It is a good many years since it was learned that a specialized clinic is of no value unless it is embedded in the network of general medical care: there has to be a physician of record to take the response from the specialist and put it to work, to follow the patient, to assure that there is compliance with medication, report untoward effects, make further referrals. But the great voluntary health agencies, prisoners of their specialist consultants, still doggedly support specialized clinics.

Some clinics have experimented with making all the specialized clinics general clinics and having the physicians exchange information or consultation as needed. In other places generalized clinics have been abolished and “family care” provided in the specialty clinic to which the patient came in the first instance. Neither of these has turned out to be a totally satisfactory solution. More models need to be tried. The medical specialists and their spokesmen in the voluntary health agencies have a special responsibility here.

As far back as 1945, in an early survey of the role and function of voluntary health agencies, Louis Dublin wrote in the introduction to that Gunn–Platt report, “In the main, the health agencies have lagged in adapting their programs to the rapidly changing needs of their communities.” There is not too much difference 27 years later. How have the voluntary agencies, for example, responded to the crisis in health care in New York City? To the demands made upon the system for change imposed by the newly fledged Health & Hospitals Corporation? To the efforts for community control of neighborhood welfare, health, and educational activities?

How did they meet the pressures placed upon their locals by the white flight to the suburbs? The health problems remain in the impoverished centers of the cities but the money fled to the ring of affluent suburbs along with other resources. Is money being bussed back to the city? Are patients being bussed to the suburbs? If not these simplistic devices, what alternative mechanisms for change or improvement have been designed? In Connecticut the VNA is talking of regionalizing programs. What about the Heart Association, the Cancer Society? What are the influential specialist advisers advising?
Many medical schools are experimenting with new approaches to teaching, in which thought is given to reorganization of health services and modification of the clinic system. What role are the clinical specialists playing in this redesign?

New problems are in the wings. Are solutions being planned? What will be the role of voluntary health agencies in HMOs? In National Health Insurance? What new kinds of workers will be trained to relieve the professional shortages and what will the voluntary health agencies contribute to the area health education centers?

It is unnecessary to continue this as a catechism. There are peripheral and central questions with which voluntary organizations and their professional cadres must deal. If the big questions are passed over while the peripheral ones are dealt with excellent answers may be derived only to find the organizations overtaken by events. The demand for an organized system of medical care is here. It is not a theoretical question. Voluntary health organizations are very important in American society as bench marks, dissenters, innovators. America will be the poorer for a monolithic system in anything. The voluntary agencies can be the instruments of their own salvation if they take imaginative and sharply delineated steps to remain alive.

The specialists and their specialty organizations are community health leaders. If they will take bold and strong positions, allies will appear who have been waiting for leadership. Again, quoting from the Gunn–Platt Report: “Those who seek to preserve the virtues of the voluntary health agencies, not merely the establishments, must catch up with the modern unitary conception of human health and welfare. They must overcome the lag in thinking.”

Each specialty group has the power to reach out to others and to their voluntary health agencies to create a common front to assist and support the development of comprehensive programs. Voluntary agencies can provide the needed added funds to top off the comprehensive efforts of the Office of Economic Opportunity (OEO) Neighborhood Health Centers and other official agency efforts, Federal and local. A new role in training health workers can be developed by identifying new types of health workers needed and giving them the training required to make them useful in the comprehensive care setting. Voluntary health agencies and their specialist constituency can broaden their health concerns, they can aid in the job of finding and feeding the hungry, the crippled children not under treatment, the unmarried pregnant teenagers, the families in need of medical care. They can organize a transport system on a voluntary base to supply the missing link between needed care and availability. None of these is categorically related to the traditional role, true. But all of these things are needed to fulfill the categorical role established over the years. The message to the specialist, to the voluntary health agency, is the same: recall the individual within whom is the organ or the disease of your concern.

It is with these things in mind that it is suggested to the specialty fields to review not the research accomplishments of which they are justifiably proud, not the services already in process but the needs of the time. The role of the voluntary health agency is to help create that network of care.