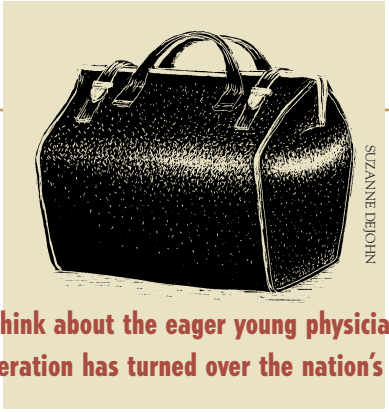
A life in medicine

By Paul J. Lena, M.D.



SUZANNE DEJOIN

I grew up in an apartment off my father's 28-bed private surgical hospital in New London, Conn. My siblings and I—who awakened every morning to the smell of open-drop ether—all opted for careers in medicine. My sister became a registered nurse, my older brother a general surgeon, my younger brother a urologist, and I a general internist. I retired a decade ago but still volunteer during the summer at a free clinic in Maine and teach during the winter in the New Hampshire-Dartmouth Family Practice Residency in Concord, N.H. So I have a present-day perspective on both the care of underserved patients and the training of new doctors.

But then I think about the eager young physicians to whom my generation has turned over the nation's health.

I have seen some amazing changes in the 50 years since my own medical training. When I was an intern, patients who'd had cataract surgery had to lie in bed for a week with sand bags keeping their heads from moving to prevent postop bleeding. Then they were fitted with "Coke-bottle" lenses that gave them little peripheral vision. Today, cataract surgery is done on an outpatient basis under local anesthesia, and patients commonly have 20/40 vision a few days postop.

Exploration: In the early 1960s, I got a call from the stepfather of one of our office nurses. He asked me to meet him in the emergency room with his unconscious daughter. She'd suffered a cerebral hemorrhage and I was afraid she might not make it to Hitchcock, 65 miles away, especially since transport then was via a hearse housed 20 miles west of Concord. Upon her arrival in Hanover, burr holes were drilled in her skull to permit blind exploration of the damage by Dr. Robert Fisher, chief of neurosurgery. Against all odds, he located and clamped the problem vessel—and she is still living. Today, however, such a patient could be examined with dynamic PET scans on the operating table, while still awake, allowing surgeons to operate almost bloodlessly in previously unreachable areas of the brain.

I could go on and on: new cancer therapies, laparoscopic surgery, stem-cell research. All these remarkable advances portend well for the technological future of medicine. But I am not as optimistic about the humanistic and socioeconomic aspects of our medical system.

I am impressed with the young doctors in our family practice residency. They are all extremely bright and have chosen the intangible rewards of primary care over specialties such as radiology or gastroenterology, in which doctors just out of residency are offered $400,000 a year. Yet I worry about the fact that some residency programs in the primary-care specialties—where we need more, not fewer, doctors—are having a hard time filling their full complement of positions.

And I also find that physical diagnosis is a disappearing art. The residents I work with are too quick to go from a brief history and a cursory physical exam directly to an order for an MRI or some other sophisticated and expensive test. I urge medical schools nationwide to recruit more retired physicians to do clinical teaching, and my retired colleagues to offer their services to nearby schools. I shudder to think of the waste of valuable clinical experience when a retired physician spends all his or her time playing golf.

Trend: A change I welcome is the increase in the number of women entering medical school—now more than 50% in some schools. I feel they bring a valuable perspective to medicine. The only worrisome effect of this trend, in my observation, is the number of such women who marry fellow physicians (often in different specialties) and the difficulties they experience finding a community that can accommodate both of them. As a result, many of these well-trained women either take part-time positions or leave medicine altogether.

I worry, too, about the environment young doctors face once they're out in practice. There are barriers today to developing the close doctor-patient relationships with which my generation was blessed. The HMO model now so prevalent pushes physicians (even in academic medical centers) to see more patients in less time—and you can't develop a close relationship in a 10-minute visit.

Even more disheartening has been the explosion in malpractice suits. This has both financial effects—raising the premiums paid by all practitioners, especially those in emergency medicine, ob-gyn, orthopaedics, and neurosurgery—and a human cost—damaging the trust that's essential to a good doctor-patient relationship. In addition, this litigious environment impels doctors to order more tests to protect themselves from suits, further driving up costs.

Care: I could go on and on: The recent cloning of a human blastosphere in Korea threatens to open a scientific Pandora's box. The barrage of drug ads on TV pushes patients to ask for fancy new pharmaceuticals, when older, cheaper drugs might serve just as well. The trend toward subspecialization is fragmenting our health-care system. The evolution of "boutique medicine" may make top-quality care available only to the well-to-do. Meanwhile, the U.S. still has some 40 million people without health insurance. And amidst all this, we face the menace of new diseases—HIV, SARS, avian flu, and mad cow.

But then I remember how far we've come since the days of open-drop ether. I remind myself that I never regretted a single day of my career. And I think about the eager young physicians to whom my generation has turned over the nation's health. Call me an idealist, but I'm sure some way will be found to fix what's broken in the present, while preserving the best of the past.

As Dr. Steven Schroeder, former head of the Robert Wood Johnson Foundation, has put it: "Don't let medicine lose its soul!" ■

The "Point of View" essay provides a personal perspective on some issue in medicine or science. Lena, a 1951 graduate of Dartmouth Medical School, practiced general internal medicine in Concord, N.H., from 1959 to 1995.