



The First Step: Shed the Ethical Rubbish



By Ed Rudin, MD

APRIL 1, 2070 — As a medical historian, I am often asked how we achieved our marvelous state of medicine.

My answer has been, "It wasn't easy."

From witchcraft to science was a torturous journey over millennia; from science to equitable delivery was equally torturous and took another millennium.

Most painful was changing practice methodology and underlying values. First came reevaluation of our ethical standards. Humankind clung to the values of the "work ethic" and "confidentiality" long after their cost was clearly more than their benefits.

For millennia people refused to admit that work generated pride, greed, anger, gluttony and envy and, through denial, sloth. Human societies fought, even killed, over economic, cultural and political theories that promised untold riches and esoteric benefits from work.

From Hippocrates to the Thirty Year War on Terrorism, people clung to their fetish of privacy and confidentiality. It pervaded all of life, and medical care was no exception. Even when everyone knew that confidentiality fragmented health maintenance and restoration, physicians demanded confidentiality.

People died because health and illness information was not available when needed; those who cared for patients, including physicians, learned to diagnose and treat without enough information or without waiting for clearances — or shared "confidential" information without regard to legal and ethical codes.

The once-powerful USA was the last civilization to jettison the work ethic and the ethic of confidentiality. Only then did it overcome more than half a century of failed attempts to make health care universally accessible, prompt, appropriate and affordable. That major shift in ethical values allowed USA communities, like the 8 million people now inhabiting the YoSac-El Dolsom twin cities to protect, maintain and restore people's health in a world that had already sustained the dramatic climate changes that occurred before we replaced fossil fuel energies with personal hydrogen generators for transportation, manufacture, heating and cooling, cooking and entertaining.

During the painful transition, physicians only fitfully and covertly challenged the work ethic or confidentiality. They joined medical systems that offered longer vacations, shorter and more regular work hours, and sick leave as needed for "mental health time." They turned a blind eye to lapses in confidentiality in order to get paid and have their practices reviewed.

Systems demanded more patient visits to capture a greater market share, more information to expedite safe and prompt service. When physicians could not responsibly deliver the demanded volume of service or the demands for disclosure, they unionized. Periodic "slowdowns" peppered the medical scene, but physicians, guilty and ashamed — and fearing greater competition from cheaper, more accessible, but inadequately trained, para-

physicians — sheepishly returned to work.

Physicians increasingly moved to medical management or left management systems and the quest for market share. Many returned to "the good old days" when patients decided what health care they could afford and rationing was by the pocketbook.. Practice was busy, even exhausting, but personal and exhilarating. It satisfied pride, but it did not ensure even basic safe, prompt and universal care. It was "retail" medicine, with all its advantages and disadvantages.

With the ethical distortions gone, physicians could comfortably enjoy a career in "wholesale" medicine: programming and consulting about electronic examinations of patients who are self-referred or referred by primary non-physician health agents. Shorter and smarter work lets physicians provide the program support and technical consultation the array of non-physician primary health agents need; the liberty of on-line sharing of patient information gave physician support to non-physician primary health agents without impediment. Physicians freely compete with their colleagues on technical program upgrades and innovative consultation techniques. Patients have a hands-on, "retail" relationship with their health agents.

All health service providers, including physicians, receive payment through electronically-negotiated, federally-enforced payment plans, so costs are low and predictable. Physician-designed programs monitor quality and block excessive or inadequate response to findings and physicians receive royalty payments for the use of those programs and fees for their consultation. Rare disputes are settled through online arbitration and mediation programs.

Physicians can also use their foot-operated keyboards to call forth all relevant government standards, statutes or regulations, ensuring that all activities and charges are lawful. Electronic mentoring, unrestricted by ancient confidentiality concerns, replaces the searches and seizures of the past.

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