Lessons from the Past

By David J. Gibson, MD

IT HAS BEEN AN HONOR to serve as editor for this *Sierra Sacramento Valley Medicine*. This special edition is dedicated to the history of medicine that enriches our region and has contributed to its resiliency and progressive tradition.

As I reviewed manuscripts for this issue, I began to feel a connection with the physicians who came before us. They were men and women of character who lived in extraordinary times.

Pay careful attention and these physicians have much to tell us about how to lead our lives, how to practice our profession and how to approach the future with optimism. Much of what they would say will disturb the comfortable among us.

Medicine is a calling

Our predecessors understood that becoming a physician meant placing the interests of the patient above self interest. There is no self interest stronger than self preservation. During the great Sacramento cholera epidemic of 1850, the population fled the city. All of Sacramento's physicians stayed and cared for the sick.

It is estimated that 800-1,000 people died in 18 days — approximately 10-15 percent of Sacramento's population. Seventeen physicians were among the dead. In another example of dedication to the patient, Drs. Morse and Stillman built a hospital in Sacramento that was ultimately destroyed in the flood of 1850. As water rose 6 inches an hour, Dr. Stillman declared, "I have some misgivings about our fate, but sure I am we will not desert the sick, and, if we are swept away, we will all go together."[1]

The fundamentals matter

The investments and priorities set by our predecessors in health care that made a difference relate to public health — not technology. Sacramento was transformed from a marginally habitable, malaria-infested swamp into the pleasant city we enjoy today because the leaders invested in the future.[2, 3] Mosquitoes were controlled, sewage treated, potable water delivered and fundamental health care (child health, prenatal care, and ultimately immunizations) provided.

Investments like these have raised the overall life expectancy in the United States in an unbroken upward trend for 100 years. In 2001, life expectancy was 77.2 years, up almost four months from 76.9 years in 2000.[4]

The trend is due to inexpensive measures like immunizing children and providing prenatal care. The infant mortality rate in the United States has now reached a record low. The major contributing cause — 83 percent of pregnant women who gave birth in 2001 received prenatal care in their first trimester.

These advances in public health and basic health care services are the legacy of health investing bequeathed to us by prior generations of physicians. The bad news from our

generation — children in poor families had a lower vaccination rate than children in families at or above the poverty level. A life expectancy gap of 5.5 years for minorities is the result.

Most states are crimping the health-care safety net for their poorest and most politically defenseless residents. An ominous new study[5] shows that up to 1.6 million impoverished and working-poor Americans — at least a third of them children — have been knocked from publicly financed health care programs in the last two years.

Obesity has now replaced communicable diseases as a health threat to our people. Nationwide, almost 65 percent of adults, or more than 120 million, are either overweight or obese, and an estimated 20 percent to 30 percent of children are overweight or at risk of becoming so.

Approximately 300,000 U.S. deaths a year currently are associated with obesity and overweight (compared to more than 400,000 deaths a year associated with cigarette smoking). Total direct and indirect costs attributed to overweight and obesity amounted to $117 billion in the year 2000.[6]

Sacramento's pioneer physicians taught us that investing in the public health infrastructure, providing basic health and prenatal care for all of our people and addressing evolving issues like obesity provides the best return in tangible benefits for the society we serve.

Unfortunately, we have not learned these lessons. Today, we counter-intuitively spend 80 percent of our health care resources on 10 percent or less of our population. Most of this spending occurs during the last two weeks of life.

This spending generates no measurable benefit and produces a high tech death with untold human misery. Our spending isolates the dying from their families, friends and community in an obscenely expensive and gilded hospital. Our priorities are barbaric. No society has ever isolated and excluded its dying while at the same time neglecting the basic health care needs of the population the way we do today.

Sacramento physicians from the past would advise that we are squandering funds on exotic, institution-based, invasive technology. It should be indulged only after basic health care is provided for everyone.

Practice medicine in a local context

How we pay for health care and make policies affecting it are, in the great flow of California's history, unimportant. Dr. LaPerriere and Dr. Fairchild point out what matters — medicine must reflect the society it seeks to serve.[7, 8]

Prior to third-party-payment, physicians were paid by their patients. Physicians prospered and suffered with the economy of their communities. Health care prices were based on the patient's ability to pay, not the employer or government's willingness to spend. With the advent of employer-paid health insurance and entitlement programs, physicians economic well-being were divorced from the state of the local economy.

During the past three years — despite a recession and an economy bordering on deflation — health costs have soared four times faster than workers' earnings.[9] America now pays twice as much per capita as other industrialized countries for health care goods and services. The consequence: the number of Americans without health insurance now equals the population of Pennsylvania, Michigan, Illinois and North Carolina combined. From 2000 through 2002 alone, the number of uninsured Americans jumped by nearly 4 million, to 43.5 million overall. Today almost one in six Americans lacks health insurance.

Compounding the inflationary trend problem, studies[10] show that approximately 30

percent ($420 billion) of the money now spent on health care is completely wasted. The average senior in Miami gets twice as many Medicare dollars spent on him as his or her counterpart in Minneapolis, but lives no longer and has no discernable difference in quality of life.[11]

Health care is facing a crisis today as it progressively loses touch with the patients it seeks to serve. The system's complexity, increasing cost, decreasing personalization, and increasing reliance upon technology lie at the core of this problem.

Every other product and service in our economy has improved in quality and grown less expensive relative to inflation over the past 30 years. Unlike health care, this has been accomplished by harnessing the benefits of technology and enhanced productivity, with increasing customer satisfaction resulting.

This progressive isolation from society cannot continue. American health care must refocus upon delivering goods and services to those it seeks to serve in a cultural context and at prices they can actually afford.

Prejudice is counter productive

Benjamin Franklin, in *Poor Richard's Almanac*, said that to think is hard work, but to hold a prejudice is sheer pleasure. Dr. Alexander Nixon not only helped create the Republican Party in Sacramento, he also represented Sacramento as a state Senator. However, he is best remembered as having cast the deciding vote to make Mary Magill, MD, the first woman physician admitted to the Sacramento Society for Medical Improvement, the precursor for the current Sierra Sacramento Valley Medical Society.[12]

Dr. Magill and her contemporary, Elizabeth Ewing, MD, had been school teachers. Both graduated from Women's Hospital Medical College of Chicago in 1884. They and their contemporaries were recognized as accomplished artists, scientists and leaders in the political issues of the day in founding the women's suffrage movement here in California. Discarding prejudice surrounding the subordinated position of women was not a stretch for Dr. Nixon and his contemporaries.

The Editorial Committee sought stories about minority physicians in early Sacramento. Dr. Franklin K. Yee's article[13] documents the role of Chinese physicians. Unfortunately, there are no articles about African American physicians — there were none at that time in Sacramento. The same can be said for Hispanic physicians.

Lest we become too sanctimonious, there is only one female Native American physician practicing in California today.[14] No sub-segment of our population suffers more from chronic disease than Native Americans.

Race and ethnic group concordance in the clinical setting is important. Concordance is a significant predictor of patient satisfaction and compliance with treatment protocols. Nationally, the percentage of race concordance by patient's race stands at 65.9 percent for Caucasians, 16.1 percent for African Americans and 22.6 percent for Hispanics.[15]

Despite the smoke over affirmative action and the lauding of our meritocracy, these facts cannot be avoided. The lack of professionals who arise from and understand the culture they serve is a disgrace that we live with today.

The lessons we draw from history will vary from person to person. What cannot be denied is that we live in the shadow of remarkable physicians who bequeathed us a profession in good standing with the public. They lived in a turbulent time, as do we. Their sage advice, based upon the circumstances they overcame, has relevance to challenges we face today.

They gave us a profession that met the needs of the society it served. They shepherded the investment of public resources to objectively benefit society. Continuing that legacy is an active rather than a passive process. I believe that the physicians of California have the

capacity to meet the challenges we face today with this same spirit — if we have the will.

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1. Early Sacramento Hospitals, page 27.
2. Echoes of Disaster, page 18.
3. A Hideous Stench, page 29.
4. The National Center for Health Statistics Report on the nation's health; 2003.
5. Center of Budget and Policy Priorities, December 22, 2003
6. "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity," December 13, 2001
7. Wagons to Sacramento, page 12.
8. Yolo County's Early MDs, page 42.
9. The Kaiser Family Foundation; 2003.
10. Fisher ES, Welch HG. "Avoiding the unintended consequences of growth in medical care: how might more be worse?" JAMA 1999; 281:446-53.
11. Ibid
12. Medical Women of the Gold Rush; Irma West, MD; this edition.
13. The Chinese Doctor's Role, page 40.
14. Dr. Laura Williams is a member of the Acjachemem/Juaneno Nation. She is currently directing the Native American Health research initiative at the UCI Center for Health Policy and Research.
15. Data from the 1994 Commonwealth Fund Minority Health Survey (MHS); Thomas A. LaVeist, PhD and Amani Nuru-Jeter, MPH. Department of Health Policy and Management, Johns Hopkins University, School of Hygiene and Public Health.

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