A day in the life

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It is late in the night (or early in the morning) as I come to the end of another day on call. I am too awake to easily fall asleep. It seems the call days are getting more hectic, or maybe I am just getting older and more easily fatigued. Is it like this for other doctors? What was it like for my predecessors? Is my perception of working hard just that, my perception? Maybe not.

The latest statistics from the College's Janus Project give the average age of Canada's family doctors as 47. It makes me wonder just who will be practising medicine in the new millennium. Are we, will they, be up to the challenge? Have we become worn down by health care reform, the cold financial reality of trying to run a practice, or the ongoing conflict between personal and professional life?

A brief examination of the past reveals that the burden of an increased workload was well recognized. Dr G.L. Gass, then President of the College of General Practice of Canada, commenting on a 1956 study in Ontario, raised the question: "The hard-working GP: does he work too hard?" The study showed that doctors saw an average of 28 patients daily, worked an 11-hour day, and spent three evenings a week in their offices. Another Ontario study in 1957 compared the workload of general practitioners with that of their specialist colleagues (**Figure 1**).

Not only was workload an issue, the very existence of family medicine was being debated 50 years ago. An interesting article appeared in the *Manitoba Medical Review* in March 1947. Written by J.C. Hossack, it was entitled "Trends in Practice and the Family Doctor."

> There are as I see it, four trends in practice. Two of these are lay and two are professional. The first of the lay trends is towards a therapeutic Utopia where everyone will have freely at his disposal all the marvels of modern medicine. There is nothing wrong about that. Sickness is an expensive business and often the cost of investigation leaves little money for the payment of cure, or cure is made impossible because lack of means has postponed attention. We are as interested as our patients in bringing about the time when sickness will no longer be for many an economic disaster.
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> The second trend is away from the family doctor. The public, fed by press, radio and picture have come to glorify the specialist. They have eaten of the tree of the Pseudo-Knowledge of medical Good and Evil. They decide for themselves which organ is at fault and none but a specialist in that organ will satisfy them as an attendant. The concentrated knowledge of the specialist makes him in their eyes good. The equally great but more visibly spread knowledge of the general practitioner makes him, for their immediate purpose, evil.
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> Thus when a woman finds herself pregnant she hies herself to an obstetrician. Her child is fed according to rules laid down by a pediatrician. He is circumcised by a surgeon, has his tonsils removed by a pharyngologist, his spots treated by a dermatologist, his hives by an allergist, his wheezes by a pulmonologist and he gets glasses from an ophthalmologist. Meanwhile the mother has been scraped, suspended and repaired by a gynecologist and for her palpitations has consulted a cardiologist while the husband most likely belches and bellyaches in the office of a gastroenterologist. The only time that the "family physician" is called is at three o'clock in the morning, when the family can't agree on which specialist is indicated and in any case fear, quite properly, that even if they hit on the right one, he probably wouldn't come as specialists are notoriously sensitive to the night air.

Contrast this with the viewpoint of Dr Maurice Hobbs, Past President of the College of General Practice of Canada in 1959-1960 (**Figure 2**).

The toll on personal life was being recognized and written about even earlier, in 1939.

> … my wife and I had come to realize one of the chief difficulties of the family doctor—the constant drain upon the emotions. To stand helplessly while relentless organisms destroy a beautiful mother, a fine father, or a beloved child, creates terrible emotional distress; and this feeling is increased by the necessity of suppression. That is why the average lifetime of family doctors is 55 years, most of them succumbing to functional impairment.
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> —*Joseph A. Jerger, MD*

And personal life often still takes second place.

> "We pay the price," said the nonphysician husband of a Midwestern physician. "We do the chores, plan family and social activities, and arrange most other activities of daily living. What concerns us most is that our physician-mates give so much emotional support to their patients and colleagues, that there is often very little left to share with us."
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> —*Dr Xenakis (1997)*

The personal price can be great. Why do we do it, then? A famous Canadian physician spoke with much insight about the doctor's life (and perhaps made a statement on the general human condition) when he wrote:

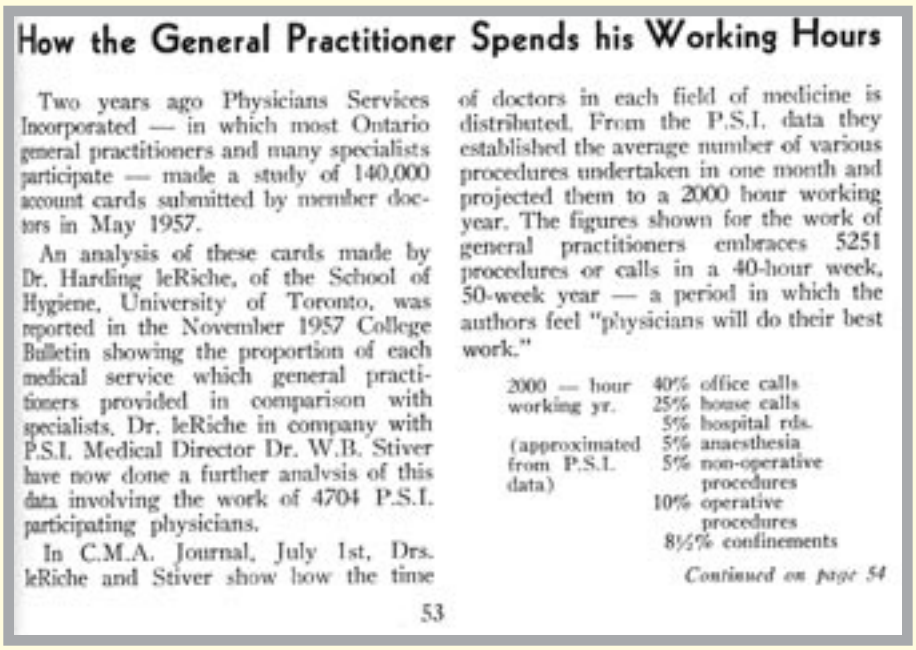
> The practice of Medicine will be very much as you make it—to one a worry, a care, a perpetual annoyance; to another, a daily job and a life of as much happiness and usefulness as can well fall to the lot of man, because it is a life of self-sacrifice and of countless opportunities to comfort and help the weak-hearted, and to raise up those that fall.
>
> —*Sir William Osler*

Again Sir William Osler seems to have been prescient when he said, "The student begins with the patient, continues with the patient, and ends his studies with the patient, using books and lectures as tools, as a means to an end."

While our patients respect the scientific knowledge and skills that we, as physicians, possess, they come to love us for the compassion and respect that we extend to them. Our advice is not usually sought because things are going well. For physical pain or anguish of the soul, we have been there and will continue to be there to provide what comfort we can. Although we view ourselves as scientists, much of what we do is encompassed by the term "the art of medicine," that nebulous quality that allows us to see the person behind the anatomy and pathophysiology.

This is perhaps our most ancient link to our predecessors: shamans, medicine men, or witch doctors. Ours is the privilege of intimate involvement in the human condition. I am puzzled that more great literature has not been written by physicians. In fact, great writers have observed this and commented on it. Boris Pasternak in *Dr Zhivago* extolled the sensitive man trying to live in the extraordinary times of the Russian Revolution.

Figure 1



How the General Practitioner Spends his Working Hours

Two years ago Physicians Services Incorporated — in which most Ontario general practitioners and many specialists participate — made a study of 140,000 account cards submitted by member doctors in May 1957.

An analysis of these cards made by Dr. Harding leRiche, of the School of Hygiene, University of Toronto, was reported in the November 1957 College Bulletin showing the proportion of each medical service which general practitioners provided in comparison with specialists. Dr. leRiche in company with P.S.I. Medical Director Dr. W.B. Stiver have now done a further analysis of this data involving the work of 4704 P.S.I. participating physicians.

In C.M.A. Journal, July 1st, Drs. leRiche and Stiver show how the time of doctors in each field of medicine is distributed. From the P.S.I. data they established the average number of various procedures undertaken in one month and projected them to a 2000 hour working year. The figures shown for the work of general practitioners embraces 5251 procedures or calls in a 40-hour week, 50-week year — a period in which the authors feel "physicians will do their best work."

2000 — hour working yr.

(approximated from P.S.I. data)

40% office calls
25% house calls
5% hospital rds.
5% anaesthesia
5% non-operative procedures
10% operative procedures
8½% confinements

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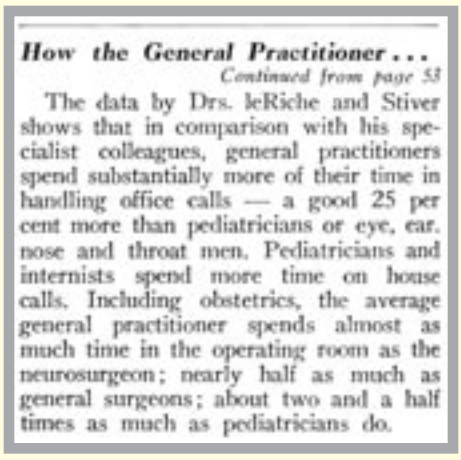

How the General Practitioner . . .

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The data by Drs. leRiche and Stiver shows that in comparison with his specialist colleagues, general practitioners spend substantially more of their time in handling office calls — a good 25 per cent more than pediatricians or eye, ear, nose and throat men. Pediatricians and internists spend more time on house calls. Including obstetrics, the average general practitioner spends almost as much time in the operating room as the neurosurgeon; nearly half as much as general surgeons; about two and a half times as much as pediatricians do.

Figure 2

IN CHANGING TIMES

BY DR. MAURICE HOBBS

Past President of the College of General Practice of Canada 1959-60

Whether we accept or reject certain social and economic trends as individuals, we must consider them in the treatment of our patients and in the conduct of our practices. The changing times are relevant to the ailments we endeavour to relieve because we treat the whole man entirely within the context of his socio-economic world. And the changing times are relevant to our practice because we too are whole men who must move with time and tide.

One manifestation of all this is that prepaid medical plans are here to stay and we must expect an ever-widening amount of them. Up to now the general practitioner has suffered where national prepaid medical insurance plans have been established. If we as a College fail to unify general practitioners in demanding proper conditions of practice and remuneration then anything else we do will be of little avail to the general practitioner.

Getting the general practitioner to think more of his capabilities, of his place in medical care, and in adopting a positive attitude of his value in total medical care — this is our job as a College. Our acceptance of responsibilities in hospitals is essential to our maturity in the eyes of our specialist colleagues.

As family physicians I think we must all encourage any program of prepaid medical care that will: (1) stimulate good medical practice; (2) enhance services to our patient families; (3) leave medical decisions in our hands; (4) return adequate remuneration for our services, but not as state employees; (5) invest us with responsibilities in accordance with our competence. Each doctor must have the privilege of treating his patients in and out of hospital. Implicit, of course, in all this is our determination that for the fundamental and common good the doctor-patient relationship should not be disturbed.

I believe that the onus is upon us to help constructively in reaching a proper solution for our patients, and for ourselves. I sincerely hope that the members of the College of General Practice of Canada — through our provincial chapters — will play a constructive role in implementing the policies of our provincial associations and in reaching a satisfactory solution for the people and the doctors of each province.

Strictly speaking the family consequences of a changing society are not our responsibility as family doctors alone; social health is everybody's job. But it is clear that we must every day in our practice endeavour to relieve the tensions that provoke hypertension and neurosis just as we remove the pressures that cause pain. Surely the long hours in treating neurotic mothers, fatigued working wives, emotionally neglected children and financially beset husbands should warrant the privilege for family doctors of being consulted by government, management and labour unions when they are considering solutions to basic social problems. That privilege — to speak out emphatically on what we think should be done for the well-being of Canadian families — is another role that I sincerely hope this College will assume with ever louder voice in the immediate years ahead.

Economic factors have undoubtedly played a part in foisting on specialists, functions which are clearly beyond their field. It is neither good medicine nor sound economics to invest with highly specialized consultants, treatment for the 85 per cent of ailments which require the generalized knowledge of the family physician. This

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must be corrected; the specialist should act as a consultant where he is needed or provide specialist treatment to the point indicated by the specialty involved. This may indeed require proper allocation of medical personnel. Today there is too much general work being done by specialists — a condition that is unsatisfactory to the specialist and to the general practitioner alike. Our specialist colleagues are anxious to stick to their own lasts and leave to general practitioners the work that general practitioners are more qualified to do. They appreciate the increasing competence of the family doctor and they give our College a good deal of the credit for enhancing the quality of general practice in Canada.

The family doctor of tomorrow should treat all diseases within his field of competence — in or out of hospital. He will call for consultation and advice referral. He must have an appointment and privileges in a hospital that lies within reasonable proximity. He will perform these functions and enjoy these privileges if we as a College continue to pursue them as diligently in the years that lie ahead as we have in the years since our founding in 1954.

Figure 3

Doctors "Average" Incomes, an Arithmetical Myth

One of the widespread and recurrent misconceptions that plagues good public relations for the medical practitioner is the matter of doctors' incomes. A prime cause of this misconception — that all doctors are rich and getting richer fast — is the manner in which the Department of National Revenue reports "average" incomes based on the tax returns of professional people, and the way in which newspapers interpret the data.

The annual statement of these figures for 1958 was recently released and it may be expected that newspapers will report that doctors are now the second highest paid members of society. This fallacy results in part from gross over-generalization of what the Department figures actually say; and in part from the use of the word "average."

The Department, and those who report its data, are using that grade school figment of calculation — the arithmetic mean. It is arrived at simply by taking the whopping big total and dividing by the number of participants. Specifically in 1958 there were 11,808 Canadian medical men filing professional class income tax returns for an aggregate $155 millions income. The arithmetic mean of those figures is an "average" $13,119, or about $500 less than consulting engineers and architects "averaged".

The distribution of doctors' incomes was quite a different story. Only one in five doctors had an income in the "average" neighbourhood; that is between $10,000 and $14,999. As with all income distributions a comparatively small group at the top account for the major part of the total. In fact, just 17½ per cent of the medical practitioners (those earning $20,000 or more) reported 40 per cent of the $155 millions. At the same time another 17½ per cent at the other end of the scale had incomes under $5,000 last year.

Nearly half of all the doctors — 47 per cent — reported incomes under $10,000 in 1958. Three out of ten made less than $7,000.

That is the arithmetic of the matter. Though this cursory analysis is illuminating it fails to note three other pertinent points that should be considered in any discussion of doctors' incomes. These points are:

1. Every doctor's income should provide, in addition to earnings for current labours, a fair return on his investment of years in training before he could accept a single fee. Businessmen expect such returns from their capital investment quite apart from their remuneration for managerial and other work performed.

2. The doctor begins his earning career when most others have long been established. This considerably shortens his lifetime earning period in comparison with others. Moreover, many doctors and certainly most general practitioners work nearly 60 hours a week. This substantially reduces the doctor's hourly income when compared with most other wage-earners.

3. Every doctor must continually study and improve his knowledge and efficiency simply to keep pace with advances in medicine. He must constantly become more proficient and this is a costly process notwithstanding that it is a dedicated aim.

"CLOSED HOSPITALS" IN HOLLAND

Terms have substantially different meanings in different places. Writing in May issue of the World Medical Journal, Dr. J. C. J. Burkens of the Netherlands defines "closed hospital" as one "which accepts only a limited number of specialists." An "open hospital" is one "at which all specialists recognized by the Royal Dutch Medical Association are allowed to practice."

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Would our generation be able to champion the personal life in the face of great adversity, to recognize the triumph of the inner self over collective homogenization? Every day, we see the dignity of the human spirit in the lives of our patients, as they try to make sense of the incomprehensible. I try to avoid sad movies and movies that capture the essence of realism; if I want a real slice of the tragic, of injustice, I can get more than a daily dose by walking through the doors of the hospital.

Awareness of the art of medicine alone, however, is only part of our duty to our patients. We are expected to be knowledgeable about the science of medicine. Think about how our predecessors approached this. They had the courage to go into plague-infested houses, to inoculate and infect themselves to prove a point, and to effect change and challenge the status quo. The pursuit of truth through evidence-based medicine has existed for a long time.

Ours is a noble profession, built on the good works of our predecessors. We owe much to those who came before us. Despite the often-expressed perception of loss of prestige, the title physician still commands respect. Lest we fool ourselves and carelessly adopt the mantle of that respect, we would be wise to reflect that this respect was hard won, and it is the task of our generation of physicians to maintain the honour of the title.

Has medicine changed? Undoubtedly, it has become more complex. The knowledge base and skill sets are getting larger each year. Do we work as hard as or harder than the previous generation of physicians? We might not make as many house-calls, but having admitting privileges in several institutions can be very time-consuming. In smaller centres, we are the full meal deal—from soup to nuts. We cover emergency departments, deliver babies, and assist in the operating room, as we have always done. Can it still be satisfying?

Concerns about the erosion of income are not new (**Figure 3**). Is there not truth to that typically Canadian cliché, being overworked and underpaid?

There is a pervasive perception that medical-legal issues are part of fin-de-siècle medicine in the twilight of this century. Advice from lawyers was, however, being offered in the very earliest communications from the College of General Practice (**Figure 4**).

Figure 4

A LAWYER'S ADVICE

1. Don't bite off more than you can chew.
2. Keep abreast of new medical developments.
3. Beware less you are accused of experimentation.
4. Warn your patients where treatment might prove fatal and obtain their written consent for the treatment.
5. Keep neat files.
6. Avail of laboratory facilities to support your diagnosis or surgical procedures.
7. Be quick to consult when you are overwhelmed by the unsuspected developments of an illness.
8. Be kind to your patients and mind your words.
9. Do not criticize a colleague under any circumstance.
10. Flatly refuse patients when you have not the time or inclination to treat them.

DR. JEAN-MARIE ROUSAL,
Medico-legal authority,
1959 Montreal Medical Society publication.

There seems to be a continual undercutting of the bastion of our profession by many in the allied professions; despite this, we can take solace in the knowledge that, when someone is sick, the person they really want to see is their mother, but doctors are a close second. Results from opinion poll after opinion poll confirm the public's trust in us. As Hippocrates said in about 400 BC, "Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician."

We are open 24 hours a day. We make things look easy because we are skilled at our jobs, and we have had excellent teachers. My first practice associate, Dr M.E. Chonko, was nearing retirement when I joined him in 1978. He made an observation that has stayed with me to this day but was just as true for him when he entered practice in 1950: "You can be sure that, when the problem seems insurmountable, it will be either the priest, the cop, or the doc that will then be summoned to help."

As we bid goodnight to a turbulent 1000 years, we should marvel at the changes and advances in medicine during that time. Will the next 1000 years be as dynamic? I would bet that some things will remain as we know them, but I would love to be around to see the changes. It has been quite a ride so far.

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