On Depersonalization in Medicine

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"The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease but little about the practice of medicine – or, to put it more bluntly, they are too 'scientific' and do not know how to take care of patients." This statement could be expected to have been made in recent years, but was made by Dr. Francis Peabody in a classic talk to the students at Harvard Medical School in 1927.[1] Although concern over a decreasing quality of the human and personal elements in the doctor-patient relationship is by no means new, there is good evidence to suggest that there are increased forces today working against the personal quality in this relationship.

These forces are only too well known to all physicians practicing today. The doctor-patient relationship is now being affected by such issues as an increasing emphasis on cost-benefit in health care, complexities of third party billing procedures, questions about confidentiality of records, changing roles of the physician in various forms of team practice, and the threat of malpractice suits for a broader range of results than actual malpractice. Our population is more mobile than in the past, expects more from medicine, and finds health care increasingly fragmented, more costly, and often less accessible and less personal. Medical practice is in a state of rapid change, and we have been less successful in distributing health care on an effective and humane basis than in developing the technology of modern medicine.

In the context of these problems and the frustration commonly felt by both physicians and patients, Menninger reminds us that caring is an essential quality of health care. In his words, "There are numerous examples of physicians who are absolutely superb technicians, with all the latest knowledge and skill, but who approach patients in such a cold manner as to prompt doubt and distress. Members of medical society boards of censors are keenly aware that patients are often so unhappy with that kind of care that they file a formal grievance. In the investigation of such complaints, it becomes clear that, more often than not, the breakdown has been in the 'caring' aspect of the physician-patient relationship – not in the quality of technical care and treatment provided."[2]

Lipkin, in an excellent book entitled *The Care of Patients* published in 1974, contributes further to this dialogue, "Caring for the patient encompasses both the science and the art of medicine. The science of medicine embraces the entire stockpile of knowledge accumulated about man as a biologic entity. The art of medicine consists of the skillful application of this knowledge to a particular person for the maintenance of health or amelioration of disease. Thus the meeting place of the science of medicine and the art of medicine is in the patient."[3] And further, "All experienced physicians know the great power of the reassurance they can give to patients who have faith in them. Fewer physicians recognize their own need for the patient's faith in them, not only to help the patient himself but to sustain the doctor's own self-confidence and self-respect. The good doctor-patient relationship is very much a two-way affair in which each contributes and receives."[4]

Amid the turmoil and debate concerning the health care of today and tomorrow, which vents frustrations by patients and physicians alike, we are indebted to these modern-day Peabodys for their constructive views on a fundamental aspect of clinical medicine. The threat of depersonalization of health care poses a critical challenge to the entire medical profession, but is particularly a concern in family medicine as that specialty taking responsibility for the ongoing care of individuals and their families. This issue requires constant emphasis and attention in our training programs if we are to develop those skills and concerns in future family physicians which will maintain the primacy of the *person* as the reason for health care.

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4. Ibid, p 212

Private Practice Management

It is important that the business and financial aspects of family practice be built on the same scholarly foundations as the rest of our material. We hope that this column, and those to follow in future issues, will provide a substantial, thought-provoking basis for dealing creatively with what might otherwise appear to be obstacles to family care. The articles will be prepared by R. J. Vargo, Ph.D., Director of Graduate Studies, and R. E. McGillivray, Ph.D., CPA, from the College of Business Administration, The University of Texas at Arlington.

Have You Updated Your Keogh Plan

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Many physicians in individual practice have had tax sheltered retirement plans for some years, but a large number of this group are not aware of the changes made by the Pension Reform Act of 1974 which has a beneficial effect upon their retirement plans.

The first change made by the act was an expansion of the amount that could be sheltered from tax each year by the physician. The amount which may be invested in a retirement plan and excluded from taxable income has been increased to 15 percent of the net income of the physicians' practice to a maximum investment of $7,500 per year. The prior restriction was 10 percent of net income to a maximum of $2,500. For physicians with a low net income, the act permits an investment up to $750 per year even though this amount may exceed 15 percent of the doctor's net income for the year.

The amount invested in the retirement plan is included in the deductions from "before tax" income and is thereby exempt from income tax in the year the investment is made. In addition, any interest or dividends earned by the retirement fund will also be exempt from tax in the year they are earned. The funds placed in a retirement plan will not escape tax forever, but the tax is postponed until the individual begins making withdrawals from the fund. It is assumed that these withdrawals will be made after the doctor retires and therefore, has less income which should result in his paying a lower tax on these funds.

A second major change in the act allows the doctor to make an investment in a retirement plan which will guarantee him a certain amount of income each year after he retires. This change became effective January 1976. Prior to 1976, a doctor was permitted to make an investment in a retirement fund, but the fund could only return the amount invested plus any earnings of the fund, or the doctor could receive an annuity equal to that which could be purchased for that amount. After 1975, the doctor is allowed to establish a retirement plan which states the amount of benefit he will receive, but it is subject to two restrictions. The annual benefit cannot exceed $75,000 or the average of the three highest years' earnings. The benefit can be any amount which does not exceed $10,000 even if that amount exceeds the three highest years' earnings. Also, the computation of the benefits received must follow the guidelines shown in the following table:

Age at participation	% of income
30 or less	6.5
35	5.4
40	4.4
45	3.6
50	3.0
55	2.5
60 or over	2.0

These percentages can only be applied to a maximum of $50,000 of earned income. Also, the percentage will remain the same for each single period of participation. However, if the amount of compensation or the percentage rate is increased under the plan, the amount of increase will be treated as though it were from a new period of participation. For example, if a doctor was to start a defined benefit plan at age 35, and his net earnings were $30,000, his benefit would be 5.4 percent of $30,000 or $1,620 per year. If no changes were made in the plan, he would be entitled to a total benefit of $30,000 per year. The computation would show a

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Selected References

The following selected references in topical areas relevant to family practice have been compiled to assist practicing family physicians, teachers, and others involved in family medicine with review, study and research. These references have been selected from computer-generated bibliographies produced by the National Library of Medicine's Medical Literature Analysis and Retrieval System (MEDLARS). It is recognized that some relevant citations may be absent on any given subject.

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