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Overmanagement of Medicine

The medical profession, which once was the most honored of all, now is under attack from many quarters and exists in what many sense to be an overmanaged condition. In part, this is the fault of the profession itself, which in its preoccupation with patients failed to keep its own house in order. Beyond that, the profession, peculiarly isolated from the political process, failed to apprehend what was going on about it. The consumer of medical services demanded his rights to know a little more. Peer review became a regulatory compulsion, and the presence of non-physicians on review committees became the order of the day. And now the logical extension of peer review, the professional standards review organization, has come to reality through legislation.

There have been other intrusions. Where once the efficacy of medicines could be established by careful clinical observation, there is a consensus today that this cannot be obtained, or must be suspect. In its place have been substituted placebo-controlled, double-blind, randomized crossover studies. However, in the overweening worship of data that lead to computer printouts for statistical evaluation, there is likely to be loss of the humane aspects of clinical investigation and clinical medicine.

On the other hand, there go unchallenged reports of iatrogenic disorders produced by improper professional use of potent medications. Such reports are neither double-blind nor placebo-controlled; they are not exposed to critical scrutiny. They suffer from fatal defects: lack of standard criteria, lack of careful evaluation, and the curse of extrapolation. Yet they lead to recriminations against the medical profession or indictments of the medicines. Following upon recriminations come regulatory responses.

So restrictive are laws becoming that we see the specter of public reporting of prescriptions and public identification of patients. The result can only be fearful physicians and undermedicated patients. We have begun to see reports of undermedication. For instance, a study by the National Institute of Mental Health in 1971 reported that "if the question is whether physicians are contributing to drug abuse by creating physical dependence among their patients. . . [then our] data indicate that most private practitioners, if anything, err in the conservative direction . . . in terms of the incidence of high levels of psychic distress one could make a good case for the point that population needs for drug treatment are not being met." More recently, there appeared in the *Annals of Internal Medicine* (February 1973) an article entitled "Under-treatment of medical inpatients with narcotic analgesics." The summary of that article indicated that some physicians were likely to exaggerate the dangers of addiction, particularly that of therapeutic origin, and to prescribe lower, sometimes ineffective, doses of drugs, even for patients with terminal malignancy. Beyond that, the National Disease and Therapeutic Index shows that the overall use of sedatives declined by 30 percent in the 7 years ending in 1972, an indication of overrestraint in the use of these types of medication that have a broad usefulness. Production quotas have been established for several scheduled medicines already, and more are being contemplated. Controls, often in conflict with one another, are proposed at state, at national, and at international levels.

If the people are to be well served, physicians must not be shackled and dispassionate discussion must prevail in the promulgation of public policy for medicine. I hope for the day when a great profession, cognizant that the responsibility belongs to it, makes itself heard.—W. CLARKE WESCOE, M.D., Vice Chairman, Sterling Drug Inc., 90 Park Avenue, New York 10016