

The lack of perspectives turns us into slaves of urgency

The medical profession is in a difficult situation as a result of the new social context and the change of conditions for the professional practice.

For most professionals, the former direct payment system (from patient to doctor) is simply a nostalgic memory. The “third payer” system has turned the doctor into an employee of what Arnold Relman has called “the medical-industrial complex”. (1)

In the United States, the implementation of managed care aimed at solving the problems that the health care system encountered in that country. Born to make health care services affordable, it has not satisfied the main expectation it was created to: reduce costs.

Since its implementation, the system has been progressively rejected by doctors and population in general. In 1998, a survey on 6,000 professionals showed 79% of disapproval of this management tool. (2)

Can a health care system work if a large proportion of physicians feel uncomfortable with it? Do patients receive proper care when their doctors are dissatisfied?

In this regard, an editorial published in *The New England Journal of Medicine* points out that the frustrated wishes to provide ideal care, the restrictions in their personal time, the financial incentives against their ethical principles, and the lack of control on their clinical decisions are some of the relevant issues that have led to the discontent of many American physicians about the quality of their professions.

They are increasingly dedicating their work time to fulfill bureaucratic requirements (which they consider to be useless and in breach), and to have meetings to get instructions about sheets and certificates, in addition to the complex administrative problems that the anarchic and fragmented health care system imposes.

In order to maintain their income, many doctors work extra hours or add more patients to their already full lists. These changes clearly take away time for their families, health, thinking, and knowledge update.

The editorial concludes that dissatisfied doctors are not likely to provide quality care.

These conditions give rise to demotivation and dissatisfaction among professionals. Research on how this depression impacts on physicians has shown a negative effect on patients because they are likely to commit six times more errors.

Argentina has also helped these organizations to establish through multinationals and then with the establishment of local entities.

Research carried out by the Research Department of the Argentine Society of Cardiology (3) evidenced

that very little remains of the proud concept “my son/my daughter, the doctor”; 25% of the Argentine cardiologists would not study medicine again, and more than 35% would not be pleased if one of their children also studied medicine.

Very little remained of that doctor-patient relationship, as simple and deep as a dialogue between two human beings. The emergence of new actors, management organizations, health care providers, and economy-based medicine affected this balance.

Professional performance has turned into an intermediary between patients and entrepreneurs.

This crisis in medicine is general and international, to the point that most of the leading magazines include an article on it in each issue.

The doctor’s proletarianization, despite being a threat worldwide, worsens in our country due to medical plethora. We do not know the exact number of physicians we have in our country; assuming we are about 140,000, if we trained 1,500 per year we would manage to maintain ourselves in that level –one of the highest in the world as far as doctor-inhabitant ratio is concerned. Nevertheless, the average of graduates per year is three times bigger the estimated number, since more than 4,000 students get their license every year.

On average, 12,500 students a year entered our universities between 1986 and 1996. In the United States of America, with a nine times larger population, the number of students entering university was 16,000.

The number of physicians a country needs and the characteristics of their training should match the intended health care system, with certain quality standards and broad population coverage.

Our country is only in the re-enrollment stage to obtain the exact number of healthcare professionals.

Argentine physicians’ training is an important issue that exceeds what is strictly academic, because it is precisely the public health what is at stake. However, debates on this issue tend to be biased in aspects related to teaching the specialty, and in political and academic struggles, while a thorough revision of the health care system –with its limitations and needs– remains pending.

Undoubtedly, we all agree on the need to ensure quality in university training, which is nowadays affected by the passiveness of the enrollment without the correlative resources necessary to achieve academic excellence. There are no economically successful countries whose universities do not provide quality training and whose entrance requirements are not extremely demanding for students.

Enrollment should be regulated according to teachers available in each university, hospital infrastructure, and number of accredited residency programs. Following that logic, there should not be more students than places to develop intensive training in hospital sites.

At present, this is possible for only 30% of the recent graduates. The rest of them will start a self-training period, with their conscience as the only supervision.

Another idea to restrict enrollment is based on the fact that limiting the access of new groups of students will result in maintaining acceptable levels of professional development. This situation is particularly true in cardiology; the cardiologist-inhabitant ratio is 4.5 higher than the optimal recommended ratio. The same surplus is present in the individual analysis of each province, and in the number of new in-training cardiologists. Regarding this point, the number of doctors in a cardiology residency program in Argentina is 18 per million inhabitants, as opposed to the 2000-2003 figures in United States, 8 residents per million inhabitants.

This number exceeds the population needs and reduces its value, as when the supply exceeds the demands.

This double problem of access and quality must be faced immediately, with no rethorics or "half-measures". A true solution must be based on a serious analysis of the problem, and must be backed up by

decisive measures that leave behind what is simply politics, and focus on technology, and above all, steer clear of the short-term perspective.

Silence and superficiality are overwhelming when discussing these issues.

The Argentine Society of Cardiology believes it must get involved in this health problem; for this reason, it has been improving relations with other scientific and State societies, in order to motivate a broad debate that will include the actors involved in this problematic issue.

We know this is not an easy task, but the clock strikes and the needs are more and more urgent; this is why creativity and willingness are so necessary.

Our societies and our leaders believe the urgency of the problems prevents us from reflecting upon long-term projects; however, it is the lack of long-term perspectives what turns us into slaves of urgency.

Dr. Ricardo Iglesias, MD^{MTSAC}, FACC

President of the Argentine Society of Cardiology

BIBLIOGRAPHY

1. Jaim Etcheverry G. *La Tragedia Educativa*. Editorial Fondo de Cultura Económica.
2. Kassirer JO. *Doctor Discontent*. N Engl J Med 1998; 339:1543-5.
3. Borracci RA, Giorgi MA, Sokn F, Ahuad S, Guardiani FM, Lowenstein DM, et al. *Estimación de la oferta y la demanda de cardiólogos en la Argentina*. Rev Argent Cardiol. 2009; 77:21-6.