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Charity Care Takes Many Forms

FOR THE FIRST TIME in the history of the medical and legal professions, the journals of the American Medical Association (AMA) and American Bar Association (ABA) jointly are publishing the same editorial today. It begins on page 3157 of this issue and is not a policy statement of either association, but rather the opinion of the editors about, among other things, physicians and attorneys providing uncompensated services to those unable to pay. The coauthors are George D. Lundberg, MD, *JAMA*'s editor, and Laurence Bodine, Esq, his ABA counterpart.

Included with that editorial in the December issue of the *American Bar Association Journal* are articles about the mandating of attorneys' *pro bono* ("for the good," the Latin term in law for work or services provided free of charge to those unable to pay) efforts by seven federal courts, two state legislatures, and seven local bar associations; the donating of more than 5000 hours of work by 35 Los Angeles lawyers in a lawsuit on behalf of the homeless; and the cutting of the budget of the Legal Services Corporation, which provides such services on a national level.

See also pp 3155 and 3157.

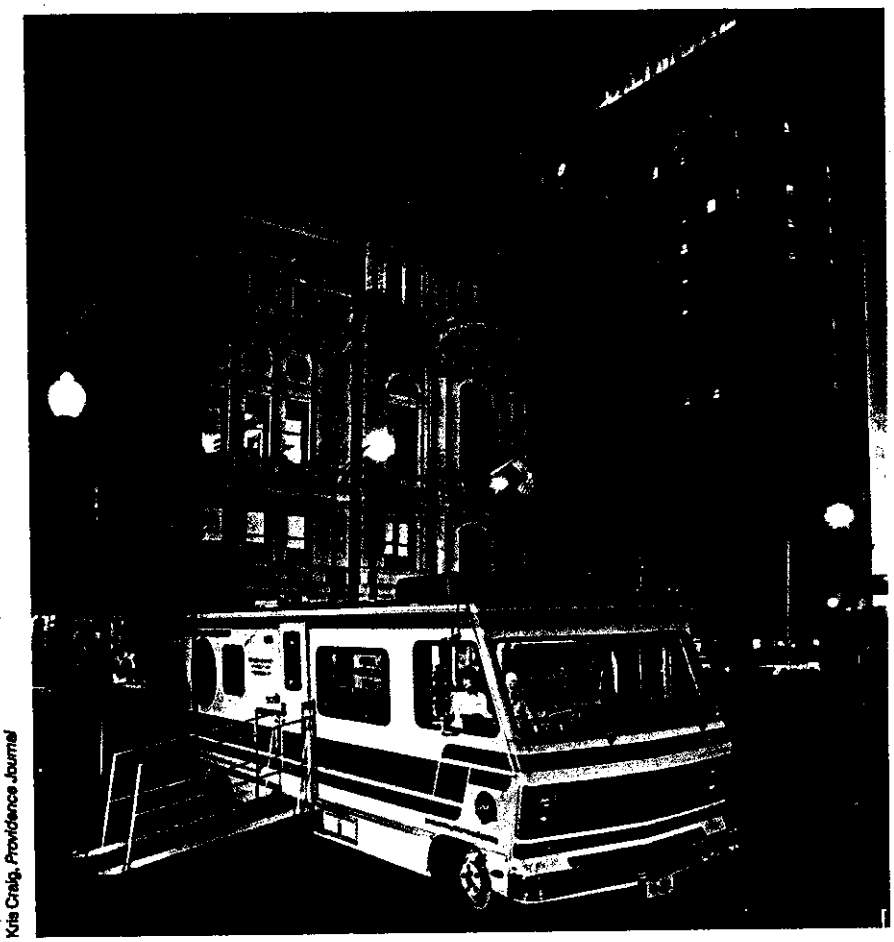
When *JAMA*'s MEDICAL NEWS & PERSPECTIVES staff contacted state and local medical associations for information about charity care by physicians, the result was such a flood of information that only a few of the individual and group contributions can be reported in the space available. With apologies to the many associations, groups, and individuals providing data that must await some future report, MEDICAL NEWS & PERSPECTIVES reports in this issue on just a sampling of an inspiring number and variety of physician charity care efforts.

In addition, John A. Rizzo, PhD, a research economist in the AMA's Department of Medical Practice Economics, reports in a study (based on 1987 AMA Socioeconomic Monitoring System data) that "17.6% of all [US] physicians are providing uncompensated care to individuals outside their regular practices, spending an average of 4.4 hours per week in providing such free care." Since some additional uncompensated care may have been provided to patients within the physician's practice, this measure may understate the total amount of uncompensated care provided, Rizzo says.

James F. Rodgers, PhD, director of the Center for Health Policy Research, of which the department is a part, notes that this is the first of a series of environmental analysis studies that will appear in the 1987 edition of *Socioeconomic Characteristics of Medical Practice*.

Rizzo's "Provision of Charity Care by Physicians" report notes also that free or reduced-fee care lowered physician

Van offers free medical care in Providence, RI.



Kris Craig, *Providence Journal*

billings by 11.9% this year, compared with 8% five years ago, and concludes that "overall provision of charity care is substantial and increasing." One explanation, the report says, "is that, in light of growing competition, physicians are more frequently reducing their fees, not only to provide care to the needy, but to compete with other physicians for patients. Another possibility is that cutbacks in Medicaid coverage have increased the number of needy individuals and physicians have responded by providing more free and reduced-fee care."

Thus, the report concludes, these data "suggest that physicians are continuing to provide substantial amounts of charity care, even though the financial burden from providing such care may be increasing. . . . Whether such behavior will be maintained as competitive pressures continue to mount is uncertain."

However, at present, the nation's physicians are providing charity care as needed in extensive and innovative ways.

Individual Efforts

The gift of medical care can be proffered through programs organized by government agencies, medical societies, religious organizations, private foundations, or community coalitions. But most often, charity begins in the physician's office. Many representatives of the state medical societies polled seemed surprised at the inquiries about official programs for charity care. "We don't need organizations. Our members provide free care on an individual basis. It's our custom to help each other out," was the response of the Vermont Medical Society. It was typical of many regions.

However, in state after state, medical society representatives acknowledged that donating care was becoming more burdensome than in the past. Mounting office costs and malpractice insurance premiums often make goodwill seem like bad business. Moreover, the regional economic reverses responsible for increasing the ranks of the medically indigent have not left physicians unscathed. The Harris County (Texas) Medical Society reported that its members' mean income had dropped 35% in the past five years.

And the specter of malpractice litigation continues to dog the good doc on charity rounds. Douglas Stauffer, PhD, executive director of the Pueblo (Colo) Community Health Center, asks, "Can a doctor donate his time and still get sued?" In that state, at least, a good samaritan statute, which is supposed to offer protection, has not been tested in the courts.

Nonetheless, legions of physicians have decided it's worth the economic sacrifice and legal risk to help out. As Stanley Hartness, MD, a family physician in Kosciusko, Miss, puts it, "You have to be able to sleep at night with what you do in the daytime."

Hartness and his two partners at the Attala Medical Clinic each see two or three patients free of charge each week. They have clung steadfastly to their decision to treat indigent patients without fee despite advice to the contrary from their practice management consultant. The partners state that the clinic, located in a town with an unemployment rate of 12% and a state with an infant mortality rate well above the nation's average, should not make money from other people's misery. They defer billing for patients who are temporarily insolvent.

Hartness, who is 45 and the parent of two college students, says that in the last year his patient load has increased, his income fallen, and his malpractice insurance risen by 40%, but that he does not plan to discontinue charity care. "You just do it," he says.

Earl Stockdale, MD, of Rock Island, Ill, would agree. "I've always felt that poor people deserve dignified and compassionate medical care, not fragmentary care from an endless array of emergency department doctors," he says. In the late 1970s, he put his principle into action, organizing a physician-referral service. Now 98% of the county's primary care physicians see, or refer to cooperating subspecialists, the medically indigent of the community. A United Way–funded hot line channels telephone requests to the appropriate provider. Since the program has been in effect, Stockdale and his colleagues have delivered more than $2 million in free care to some 10 000 patients.

Salt Lake City pediatrician Joseph Cramer, MD, shares their sentiments. Cramer spends Wednesday afternoons at a compound of derailed boxcars that have been converted into temporary living quarters for homeless families. He donates his services to a clinic operated by Intermountain Health Care, Inc, a nonprofit hospital system.

The clinic is part of a program inaugurated in 1984 when Salt Lake City officials asked the hospital corporation to provide medical care at its newly instituted shelters for the homeless. It sent nurses and nurse practitioners to the shelters three evenings a week. Although these health professionals could refer patients to physicians, there were none on the premises.

Newspaper accounts of these programs piqued Cramer's interest. "He just called up, said he wanted to work with us, and set up times when he could take care of people with no strings attached," explained Wesley B. Thompson, Intermountain's director of medically needy services.

"This is no big deal," Cramer says. "I got sick of hearing doctors gripe about the state of Medicaid reimbursement. I was also tired of doing the paperwork involved in reimbursement. I decided to bypass the system and give my time."

Helping the Homeless

In other areas of the country, the plight of the homeless has inspired similar gifts of service. Homeless teenagers are the designated beneficiaries of a program developed by the Providence (RI) Travelers' Aid Society. The society used $50 000 seed money from Gulf & Western Industries, Inc, New York City, to establish a mobile medical facility for runaway youths.

Gastroenterologist Herbert Rakatansky, MD, has recruited a staff of volunteers, which now numbers 40 physicians and 50 nurses, to work on a rotating basis. In a van stationed in downtown Kennedy Plaza from 6 to 10 PM each weeknight, they give physical examinations, take samples for bacterial cultures, and offer psychological counseling. They also make referrals to medical centers for serious illness, human immunodeficiency virus testing, and pregnancy testing.

Patients visiting the van are required to identify themselves by first name only; few records are kept. The staff's willingness to preserve patient anonymity coupled with its unwillingness

Los Angeles' Tent City

Ken Lubas, *Los Angeles Times*

to turn anyone away has made the van a popular fixture on the Providence night scene. In September, volunteers examined 143 patients, less than half of whom were teenagers.

Volunteer physicians in Los Angeles were even busier. They examined more than 800 homeless persons in one day—July 25—in Los Angeles. "Mission Physicians" day, as it came to be known, attempted to publicize the medical plight of those for whom the city-spon-

Clinton Giese

Dr Cramer

sored Tent City provided temporary asylum.

St Petersburg, Fla, surgeon Daniel Stein, MD, spent his vacation organizing the effort. He was aided by psychiatrist Milton Greenblat, MD, gerontologist John Bosco Lima, MD, Peter Vash, MD, MPH, and dentist Morton Green, MPH, DDS. Stein acknowledges that the clinic was merely a "stopgap measure," but says the effort was intended to inspire physicians to plan similar efforts in other cities with large homeless populations.

The Working Poor

While the homeless are the most dramatic example of the medically indigent, the "working poor" account for the greatest numbers. These are the millions who make too much to qualify for Medicaid but too little to afford private health insurance. They often work part-time or at a minimum wage for small businesses that are not required to offer group health insurance.

In many communities, hospitals, churches, and regional governments have collaborated to provide clinics that dispense low-cost care to such patients. Those that succeed seem to have a common denominator: a large volunteer professional staff, all of whom work only a few hours a month.

The Church Health Center in Memphis, which opened its doors Sept 1, may become the model for such efforts. Located in a renovated boardinghouse, the center provides outpatient examinations, diagnostic imaging, laboratory services, and prescription drugs at nominal fees.

The average fee of $10 per visit, calculated on the patient's ability to pay, does little to defray expenses. Most of the center's $375 000 annual budget is donated by church groups and four Memphis hospitals.

Of necessity, salaried staff is held to a minimum. The director, Scott Morris, MDiv, MD, a Methodist minister who is board certified in family practice, is the only physician on the payroll. He needs the assistance of 60 other physicians who volunteer an evening every two or three months to handle the 12 000 to 15 000 patient visits expected in the clinic's first year. Patients with serious illness are referred to specialists who have agreed to treat two or three patients free of charge each month.

Morris has also enlisted the help of the community's clergy to provide counseling for emotional problems and to do preliminary medical screening. He offers a ten-week training course to enable them to spot certain medical conditions and refer patients to the clinic.

Finally, working with the Memphis Dental Society, Morris has arranged for 50 dentists to volunteer an evening in the clinic's dental suite, which is under construction. Dental care soon will be available two or three nights a week.

The Uptown Community Clinic in Minneapolis offers similar services. The clinic in the heart of the city is funded by grants from local governments and donations from two hospitals. Its pharmacy is stocked at reduced cost by pharmaceutical companies.

The mainstays of the clinic are its almost 100 physicians who volunteer three or four hours of service a month, most of whom are relatively new to practice and have fewer demands than their senior colleagues. However, medical director David Olson, MD, who began as a volunteer shortly after completing his residency in obstetrics and gynecology, has been on staff for 13 years. He reports that one of the rewards of long service is seeing a few clinic patients move into the economic mainstream. In fact, a few have come to his suburban office as private patients.

Anyone who doubts that such clinics can survive need only look at the People's Clinic in Boulder, Colo, which has offered prenatal, pediatric, and adult health care since 1970. It and a satellite, the San Juan People's Clinic, which opened in 1980, are staffed by 150 volunteer physicians, physician assistants, and nurse practitioners. In 1987, the two logged 25 000 patient visits.

The clinic staff is supplemented by 80 specialists who accept office referrals and by 50 lay advocates—volunteers who are trained to take medical histories and provide health counseling. The volunteers may be called on to translate the patients' Spanish, Hmong, Cambodian, Vietnamese, Lao, or Thai.

Medical Societies

State and local medical societies have demonstrated their forte: organizing far-reaching efforts. The Kentucky Physicians Care program is one of the largest, counting 2255 of the state's 5000 physicians among its members. They are recruited by the Kentucky Medical Association, which provides most of the office space and staff for the program. Physicians agree to provide one office visit free of charge to patients who are ineligible for Medicaid and have incomes less than twice the poverty level.

Other organizations handle additional aspects. A statewide toll-free line for patient referrals is funded by the Kentucky Health Care Access Foundation; the Kentucky Cabinet for Human Resources determines patient eligibility.

In conjunction, nearly 85% of the state's hospitals voluntarily participate in the Kentucky Hospital Association's Fair Share program, agreeing to commit a percentage of their revenue to indigent care. Some laboratory and radiological services are donated and manufacturers' drug samples are passed on to patients when possible.

The Medical Society of the District of Columbia recently instituted a volun-

Mike Sergieff, *Los Angeles Herald*

Dr Stein

teer referral service to link physicians with a diverse group of facilities, including the Clinica del Pueblo, established primarily to help Hispanic refugees; Columbia Road Health Service; Community of Hope Health Services; Community Medical Care; SOME (So Others Might Eat) Clinic, which serves homeless adults; Washington Free Clinic; and Zaccheus Medical Clinic.

Members of the Green County Medical Society have established a walk-in

clinic for those who don't have access to medical care in Springfield, Mo. Its staff is drawn from a list of physician-volunteers compiled by the society after a survey indicated that more than half of its members were willing to donate medical services to indigents not receiving government assistance.

In Colorado Springs, Colo, the El Paso County Medical Society places four members on the board of the Community Health Center. While the center, a private nonprofit corporation, offers primary health care through its staff internists, pediatricians, and obstetricians at two ambulatory facilities, the medical society has gained commitments from 130 specialists and 28 dentists to provide office care to referral patients free of charge.

Operation Care, founded by the Shreveport (La) Medical Society in 1983 during a period of massive layoffs in the oil industry, is defined as a "recession referral service." More than 60% of the region's physicians have volunteered their services free to patients who are out of work and without Medicaid.

Asked to explain why physician participation in such programs was so high, one of Operation Care's founders, Milton Chapman, MD, said that his colleagues subscribe to the tenet that health care should be delivered to the sick and not to the pocketbook. Salt Lake City's Cramer has another theory: "There's a lot of gratification in this kind of work. It helps to keep things in perspective."—by the staff of *JAMA* MEDICAL NEWS & PERSPECTIVES with *JAMA* senior medical elective participants Erica Frank, Mercer University School of Medicine, Macon, Ga, and Marianne Gillow, Medical College of Pennsylvania, Philadelphia.

20 Years After First Human Heart Transplant, 1987 May See 4000 Procedures Performed Worldwide

THIS WEEK marks the 20th anniversary of the first human heart transplant (*JAMA* 1967;202:23-24). Christiaan N. Barnard, MD, PhD, the surgeon who performed that transplant, recalled in a recent interview the events leading up to the historic operation.

See also p 3142.

Cardiac transplantation to Barnard was merely a "new surgical technique." He began to think human heart transplants might be feasible when he read of a technique in 1959 in which the posterior walls of the recipient's atria were left behind. "Immediately, cardiac transplantation became a very straightforward surgical technique because it meant that you didn't have to anastomose the two vena cavae and the four pulmonary veins—all you had to anastomose were the two atria," he says.

After studying for several months in the United States, Barnard, who is currently a scientist-in-residence at the Oklahoma Transplantation Institute, Baptist Medical Center, Oklahoma City, returned to South Africa ready to begin the patient-selection process. The criteria he and his colleagues decided on included "extensive destruction of the heart muscle" and "terminal heart failure not responding to intensive medical treatment" and not correctable by simpler surgery.

The primary indication for a heart transplant today is still end-stage heart disease—either cardiomyopathy or ischemic heart disease—notes Norman E. Shumway, MD, PhD, Field Professor and chair, Department of Cardiovascular Surgery, Stanford (Calif) University Medical Center, whose group has performed more than 500 heart transplants.

Aware that he might be subject to criticism if he chose a black donor or recipient on grounds that—at least in South Africa—this might be considered experimentation, Barnard decided to wait for a white donor even though a black donor was available several weeks earlier.

On the afternoon of Dec 2, 1967, a young woman was brought to Groote Schuur Hospital in Cape Town after being struck by an automobile. She was declared brain dead and was maintained on a ventilator while Barnard and his colleagues sought permission from the woman's father and performed histocompatibility tests. They decided to proceed with the transplant (*Am J Cardiol* 1968;22:584-596).

Again concerned about criticism, Barnard waited to open the woman's chest until he had disconnected the ventilator and the heart had stopped beating. Meanwhile, the recipient, a 54-year-old man with severe congestive heart failure, was connected to a cardiopulmonary bypass machine in an adjacent operating room. The operation lasted into the night and was completed without any apparent complications.

Commenting on his first postoperative observations of the patient, Barnard said, "The *thing* that was absolutely amazing and very gratifying was to see how quickly the edema disappeared. . . . That was the first time we were able to observe that, because our experimental work was, of course, not done in animals in severe heart failure."

The patient died of pneumonia 18 days later.

Barnard says now that if heterotopic transplantation had been feasible at the time (it was not developed until 1974)

A 1967 photograph of many of those involved in the first human heart transplant. Christiaan Barnard, MD, PhD, is in rear row.

Christiaan Barnard, MD, PhD

Unconscious on a Corner . . .

THE POLICE brought Mr W. to the emergency room. They had found him unconscious on a corner in Washington, DC, one more drunk littering the city, disturbing our view. Fifty-two years old, black, dressed in rags, homeless, he was no different from the countless other tragedies that find their way to the ER. But Mr W. was not drunk. His jaw had previously been broken and—at another emergency room—wired shut to heal, whereupon he had been discharged back to the streets. He couldn't eat or drink enough to keep himself going, and so it was that the police found him, severely dehydrated, unconscious, close to death.

For editorial comment see p 3157.

Mr W. was initially rehydrated with intravenous solutions, but his condition deteriorated, and he was readmitted to the intensive care unit. Tests were ordered, examinations repeated, consults held. At last it was clear: Mr W. had the syndrome of inappropriate antidiuretic hormone secretion with life-threatening hyponatremia. Fluids were limited to 800 mL per day, his physicians went out of their way to find demeclocycline (an expensive medication not routinely available at the hospital), and Mr W. was slowly and painstakingly nursed back to health.

Without reference to the chart, his physicians explained to me in detail his prognosis and continuing treatment; clearly they knew their patient well. Mr W. would be returning to a city shelter in a few days and the medical team would follow him up in the outpatient clinic. And as I reviewed the chart, I was impressed with our city hospital. Compassionate, competent care had obviously been rendered this homeless man without reference to his finances, social class, or culture. In my work with the poor, I was used to stories that ended differently; Mr W.'s story gave me hope for the wounded of our society.

As I walked into Mr W.'s room, however, my hopes dimmed. I was shocked by his emaciation, by the emptiness in his eyes, by the light slowly but definitely extinguishing. He was confused. Now "ready for discharge," he could not remember the day of the week, the month, or even guess the year; he seemed unaware he was in a hospital. Clearly Mr W. was demented.

How could he be discharged to a shelter? How would he manage to take his medicines if he couldn't even remember the day of the week? How would he limit his fluid intake if he couldn't understand instructions? How could these obviously compassionate physicians send this man back to an overnight shelter from which he would be sent out into the street to forage for himself every day? Mr W. had been well treated initially; why was he being abandoned now that his treatable condition had been corrected?

I talked to his physicians, trying to understand. No, they didn't really know what the shelters were like. They didn't know that there was essentially no supervisory staff, that meals were unavailable, that ten men would be herded together in one room shared with cockroaches and other vermin, that alcoholism and random violence were uncontrollable. Without a conscious decision, it has become policy in our city to consider overnight shelters as places of disposition for emergency rooms, jails, prisons, and hospitals. I could hardly blame Mr W.'s physicians for following usual policy.

The issue, however, was deeper. When Mr W. first entered the hospital, there was indeed something that his physicians could *do* for him. They had the knowledge, they had the resources, and they could *do some good*. But now that time was over and he was "cured." There were no more diseases to treat. Furthermore, there was no place to send him. In Washington, nursing home placement for the indigent can take over six months, and the physicians knew there would be intense pressure to discharge their patient from his expensive hospital bed. They knew no other options. So, their honest compassion had no place of expression and they had withdrawn. They hardened themselves to the reality of Mr W.'s plight and talked about discharge to a shelter as if that were a legitimate plan for a demented old man who needed constant supervision.

Are not many of us like Mr W.'s physicians? Within us are deep wells of compassion that—given the right set of circumstances—can be tapped to generate enormous generosity and creativity. But the truly broken—the chronically schizophrenic, the alcoholic, the homeless, the very poor—seem beyond our caring. Their needs are overwhelming, the structures that reach out to them so few. We don't know what to do, and so we turn away, offering nothing. Compassion is exiled.

After four years of working in the inner city, it is clear to me that medicine has largely abandoned the poor. Private medicine in Washington is inaccessible without insurance cover-

From Community of Hope Health Services and the Christ House Medical Recovery Shelter, Washington, DC.
Reprints not available.

age. We called at random 50 private primary care physicians; less than half accept Medicaid for payment. Fewer than 10% have any provision for reducing fees or for deferred payment for uninsured, indigent patients. Unless one can pay the $75 to $150 office visit fee in advance, there is simply no way to get in the door.

And so the poor must rely on the public sector, on the good will of a society that has no use for them. Government budget cuts are no longer news, and an aging, fragmented bureaucracy delivers distinctly second-class care.

The reasons are multiple and complex, but the final reality is painfully obvious. The poor are denied access to adequate health care. Every day we see the scars among our patients: an ataxic, demented alcoholic who can barely balance with a walker is discharged to live on the streets; a hypertensive woman suffers a stroke because she cannot afford her medicines; a one-legged man with the remaining foot frostbitten is discharged from an emergency room with instructions to soak what is ultimately shown to be osteomyelitis. What has happened? How can the richest nation in the history of the world permit such tragedies?

The "monetarization"[1] of private medical care and the inadequacy of the public system are certainly the most important reasons for the abandonment of the poor. It is difficult for us physicians to maintain our average $108 000 annual salary and still provide care to the indigent. Medicine is quickly changing from a servant profession into a business and it is the poor who are most deeply affected. And it is also easy to blame a public system in which only 31% of the poor even *qualify* for Medicaid,[2] of which bureaucracy and second-class care are the hallmarks. But there are more subtle reasons than money and an unresponsive bureaucracy for the medical abandonment of the poor.

I would suggest that it is difficult to be a highly trained physician and work with the poor. Most of us come from a different culture and do not understand, for instance, that the very poor are often so overwhelmed by the emotional, social, and financial stresses in their lives that they simply cannot comply with our evaluation or treatment. If a patient cannot articulate his history, has a fourth-grade education, compounds his hypertension with alcoholism, cannot afford laboratory evaluation or medications, is unable to return for consistent follow-up because of problems at home, and cannot afford a place to live, we who are trained to treat diseases[3] will feel at sea. The physicians who treated Mr W. could express their compassion by diagnosing and treating his rare hormonal disorder, but they were deeply frustrated by his dementia and his homelessness, by the years of despair that had left him without resources. We who are used to the efficiency and power of conventional doctoring find this new work very demanding emotionally.

Most frustrating is the absence of self-esteem among my patients. Because so many come out of generations of poverty, they *know* that they have little value in our society; it has been demonstrated to them over and over again. There is little sense that anything they can do will make a real difference in their lives.

And so, too often my medicine doesn't work; my attempts at care fail completely. Often I feel that the most I can do is be present, be there when I can, help a little, and try to keep my own head above water. There is little sense of accomplishment for me as a physician, and I become discouraged.

There is a deeper reason, too. To work with the very poor—especially the inner city poor—is often to work with people who are very broken. Even the children have such wounds at 7 and 8—or even at 2 or 3—that a normal life would be a miracle. Some of these people will never be healed, if by "healed" one means becoming a functioning member of society.

It is not easy to open ourselves to the pain, suffering, and vulnerability of the poor. We have to confront our own limitations. We know that it does little good to offer a medication when our patient needs a home, a meal, a family, love, money, and a thousand other things that we ourselves take for granted. We also confront the limitations of a society that refuses to accept responsibility for its broken ones. And so it is tempting to turn away, offering nothing, sparing ourselves the deep frustration.

The medical abandonment of the poor thus becomes a paradigm for society's refusal to face its own brokenness. We herd the poor into ghettos so that we do not have to face our own vulnerability, our own dark sides. Our own woundedness can thus be denied for a little longer while the sores fester unseen in "those others." Sölle[4] has suggested that when we thus participate in injustice without struggling against its inhumanity, we are overcome by an "objective cynicism" that leaves us alienated and hopeless, choosing death. We find ourselves deeply wounded by our refusal to care for the poor.

What can be done? Clearly our institutions need to change. Clearly some form of national health coverage available to all the poor is required. Without guaranteed health insurance, nothing else will be of much use. But, given the current social and political atmosphere, that change will be a long time coming. There is the danger that by focusing exclusively on what needs to happen in the political system, we will avoid the deeper, more personal transformation that is also necessary.

Can we who are in private medicine open, say, 15% of our practice to those who cannot afford the full fee? Can we accept Medicaid—with all its paperwork, discounts, and headaches—joyfully as an opportunity to participate with our society in ministry to the poor and oppressed? Can we who belong to medical institutions press our employers to do the same?

The first step must be to bring the poor into our practices. In our city, over 200 private consultants—coordinated by the Archdiocese of Washington—have volunteered to serve as a referral network for indigent patients; radiology and laboratory services have been similarly offered. It is only a beginning, of course, but it opens us to the possibility.

I am beginning to realize that we in medicine need the poor to bring us back to our roots as a servant profession. Medicine drifts understandably yet ominously toward the technical and the economically lucrative, and we find it difficult to resist. Perhaps we *need* the poor at this very moment to bring us back to ourselves. The nature of the healer's work is to be with the wounded in their suffering. Can the poor in their very vulnerability show us how?

David Hilfiker, MD

1. Ginzberg E: The monetarization of medical care. *N Engl J Med* 1984;310:1162-1165.
2. *No Room in the Marketplace: The Health Care of the Poor.* St Louis, Catholic Health Association's Task Force on Health Care of the Poor, 1986, p 2.
3. Baron R: An introduction to medical phenomenology: I can't hear you while I'm listening. *Ann Intern Med* 1985;103:606-611.
4. Sölle D: *Choosing Life.* Philadelphia, Fortress Press, 1981, pp 1-19.

Editorial

Fifty Hours for the Poor

This editorial also appears in the December issue of the ABA Journal, The Lawyer's Magazine.

Doctors, lawyers, and the clergy belong to the classic learned professions, which are historically distinguished from trades and businesses. Although this distinction has blurred in modern times, one of the characteristics of a true profession remains its special relationship with the poor.

See also p 3155.

Edmund Pellegrino, director of the Kennedy Institute of Ethics, states that a fundamental difference between a business and a profession is that "at some point in the professional relationship, when a difficult decision is to be made, you can depend on the one who is in a true profession to efface his own self-interest."

The privilege to practice law or medicine has carried with it the obligation to serve the poor without pay. Doctors and lawyers today have tended to become overly concerned with their professional incomes and practice efficiencies, but they must not forget their higher duties. Many members of our professions have always cared for the poor who need legal or medical help. But their efforts are not what they should be, and there is abundant evidence of unmet needs. For example, 35 to 50 million Americans are now believed to be medically uninsured or seriously underinsured; access to health care is widely considered to be in crisis. For 68% of legal problems encountered by poor people, the services of a lawyer are not used, according to the American Bar Foundation.

The philosophical and ethical roots of the medical and legal professions are entwined with the public interest, service to the community, and caring for the poor. These professions maintain those values. In law, the official policy of the American Bar Association, adopted in 1975, states:

> It is a basic professional responsibility of each lawyer engaged in the practice of law to provide public interest legal services without fee or at a substantially reduced fee in the following areas: poverty law, civil rights law, charitable organizations representation and administration of justice. It should always be provided in a manner consistent with the Model Rules of Professional Conduct. The organized bar should assist each lawyer in fulfilling his responsibilities in providing such services as long as there is need, and should assist, foster, and encourage governmental, charitable, and other sources to provide public interest legal services.

In medicine, the American Medical Association's original code of ethics, written in 1846, emphasizes relief of pain and diseases without regard to danger or personal advantage and states that "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded." In 1987, the American Medical Association House of Delegates approved as policy: "That the AMA urge all physicians to share in the care of indigent patients." Principle 3–6b of the Health Policy Agenda for the American People states that, "All health care facilities and health professionals should fulfill their social responsibility for delivering high quality health care to those without the resources to pay."

How many members of the legal and medical profession now deliberately care for the poor in a voluntary and uncompensated way? Many, but not enough. What percentage of their time is spent doing so? Much, but not enough. Accompanying articles in this issue of both the *ABA Journal* and *JAMA* explore these questions in some detail.

Doctors and lawyers in our society have benefited greatly from the abundant opportunities made available to them from the fruits of our plenty. We believe that all doctors and all lawyers, as a matter of ethics and good faith, should contribute a significant percentage of their total professional efforts without expectation of financial remuneration. This percentage will vary depending on time, setting, opportunity, and need, but all should give something. This is the proper behavior of a learned professional. We believe that 50 hours a year—or roughly one week of time—is an appropriate minimum amount.

There is a great tradition behind the giving of this gift. In the church, it is called *stewardship*. In law, it is called *pro bono publico*. In medicine, it is called *charity*. In everyday society, it is called *fairness*.

George D. Lundberg, MD
Editor, *JAMA*
Chicago

Laurence Bodine, Esq
Editor and publisher, *ABA Journal, The Lawyer's Magazine*
Chicago

JAMA 100 Years Ago

September 3, 1887

Tenement Crowding

NEW YORK CITY BOARD OF HEALTH.

Under the *régime* of the new President of the New York City Board of Health, Mr. Bayless, as was to have been expected from his recognized ability as a sanitary expert and his well-known public spirit, the Health Department has been placed in a more efficient condition than has been the case for some years previous. . . . A number of important improvements . . . have been inaugurated. . . .

Another very important work that the Board has undertaken is the prevention, as far as possible, of over-crowding among the tenement-house population; which would seem to be a pretty difficult matter in a city like New York. A recent writer in the *Forum* thus describes a single block, 200 by 700 feet, in a tenement-house district: "On all four sides are rows of tenements four or five stories high. Behind one-third of the houses in these rows are rear houses, with smaller rooms, darker and dirtier passages, backed by another rear house, a brewery, a stable, or a factory. Altogether there are 1,736 rooms. In these rooms live 2,076 persons, divided into 460 families; thus, on the average, each family of five persons occupies three rooms." In some parts of the city the population is equivalent to 290,000 to the square mile; while the most densely populated part of London, proverbial for its misery and wretchedness, has 170,000. Cases have been known in this typical block in which 14 or 15 grown persons occupy two rooms, or even one. Many of the rooms, too, are nothing more than dark closets. About all the bedrooms in fact, measure but 7 by 9 feet, with one door leading into an apartment that serves a kitchen, parlor, dining-room, sitting-room, laundry and workshop, and one window that opens on a dark stairway, up which moisture from the cellar and sewer gas from the drains are constantly likely to rise. Under such conditions disease is a frequent visitant and death an incident so common that it ceases to be impressive. "The corpse," says the writer in the *Forum*, "lies for two days in the room where the family eats, works, and often sleeps."

The Board of Health has issued orders to its inspectors to report all cases in which (1) the over-crowding is due to boarders taken in, not members of a family; (2) in which there are not 400 cubic feet of air for each adult and 200 feet for each child under the age of puberty, and (3) where the ventilation is insufficient. Recently quite a number of tenement houses have been ordered to be vacated as being entirely unfit for human habitation, and in a recent letter addressed to President Bayless, Mayor Hewitt says: "I am aware of the disorganized condition of the department when you entered upon your duties, and I am convinced that you have done all in your power to bring order out of chaos. Before the close of the present year I hope to be able to inform the people of New York that every tenement which is unsuited for healthy occupation of its citizens has been vacated. . . ."

Regulations in regard to plumbing and ventilation have also been adopted, and under these there is to be an entire abolition of what is known as the "school sink" in tenement houses, and the substitution therefor of water-closets. Provision has also been made for the use of extra heavy cast-iron pipe in all cases, and the use of tarred iron pipe will not be allowed. All closets must be connected with the outer air. Among the other evidences of new vigor in the administration of the Health Department is the prosecution of a number of physicians for neglecting to report births and cases of contagious disease occurring in their practice.

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