

Guest Editorial

What is Wrong with American Medicine? The Role of IMANA

Assalaamu alaykum

Dear IMANA Members:

As I returned from the 42nd annual convention of IMANA in Washington, DC, the nation's capital, I felt very invigorated because I see a great future for IMANA in the United States. IMANA and Muslim physicians in America have to play a great role in the future of health care delivery, not only in the United States, but also in the rest of the world. Islam brought to this world the message of compassion, caring, and respect for all our fellow humans. As physicians, we all know that American medicine, although technologically highly advanced, still has great shortcomings. Unfortunately, American medicine, with all of its collective wisdom and innovation, embarked on a wrong path for the delivery of health care to the masses. This mistake was that it made medical care a commodity to be commercially traded rather than a compassionate nonprofit treatment for the sick and the suffering. Now, in the 21st century, American medicine is already paying the price for the wrong decisions it made. We all know that in this country, the cost of health care delivery is escalating so quickly and so precipitously that it will soon become unaffordable, not only for the individual, but for the entire nation. President Obama and all other leaders recognize this, and now, in order to save this sinking ship, they are proposing draconian measures and drastic health care reform. These reform measures are not likely to be easily accepted by a system that has grown accustomed to waste, excess, and corporate greed.

In a lifetime of medicine, I have had the opportunity to practice medicine in four countries on three continents under totally different health care systems. I started my medical career in India. The health care offered there was mostly private with the care of the masses left to bureaucratic, ineffi-

cient, and poorly run — but free — government-owned hospitals and clinics, which offered no more than minimum care. Those who could afford to do so got somewhat better care by paying for it. Even then, one was never assured of getting honest and optimum care, because of common, deep-rooted ethical malpractice. Kickbacks and moral corruption of physicians were fairly commonplace, quackery abounded, and there was little or no compensation for the patient who suffered medical malpractice. Most of the problems in the Indian health care system were a result of the nation's weak economy as it emerged from the shackles of colonialism, overpopulation, poverty, and illiteracy among the masses. In recent times, India has made tremendous progress due to its rapid economic growth and growth of human potential, and now medical care available in India is comparable to that found in developed nations. It has become attractive enough that even patients from more affluent countries, such as the United States and the United Kingdom, go to India for high-tech treatments and pay considerably less than they would in their own countries. This care has to be made available to the masses and hopefully this will happen as the country emerges from a poorly developed nation to a fully developed one.

I subsequently had the opportunity to practice medicine in England for several years. The system of medicine there was socialized and provided by the government, which got its revenue from fairly heavy health care taxation called the National Health System (NHS) and collected from all eligible citizens. The medical care for the vast majority of the people was of a higher caliber than what I had experienced in India. Centralization of resources in highly specialized centers made specialized care accessible to the common man, with the only cost to the individual being the taxes that he or she had to pay for health care. This socialized system of health care had tremendous advantages from the standpoint of the

recipient and made reasonable health care available to the common man. However, it had its disadvantages as well. It resulted in long waiting lines, especially for elective therapy. One had to wait for all but the most urgent and emergent of therapies. We had a funny saying for the NHS: it was better to register for a procedure before you developed the condition, so that when you did develop the condition you could get your turn quicker to get it treated. Private care was also available for those who could afford to pay for it, above and beyond the health care tax, and helped in avoiding the NHS waiting lines.

My next country of practice was in Saudi Arabia, where I worked as the chief surgeon of a hospital controlled by Aramco, the largest oil company in the world. Although my exposure to Saudi medicine was brief (two years), I did get enough insight to form opinions regarding Saudi medicine. In the 1970s, the Saudis had just started to utilize their new-found oil wealth. They had the intention of providing the best possible care to their citizens. What was lacking was the human capital. Very few Saudis had been trained in medicine, resulting in them having to rely on imported labor from other countries to fulfill their needs. This hampered the progress that they could make. They were not short of finances, but finances alone could not achieve the ambition of delivery of health care. I visited a very well-funded Saudi government hospital and found that it had imported the latest equipment for medical tests. However, much of it lay unused in closets for lack of expert maintenance, resulting in patients being deprived of the benefit of this equipment. Most of the doctors who were working for the system regarded their positions as temporary, or only a passing phase of their medical practice (much like it was for me personally) and hence they were not truly interested in long-term delivery of care. Also, the system the Saudis had created to hire medical labor was ill-conceived and full of prejudice. There were tiers of pay scales. For exactly the same work (*viz* a surgeon or a nurse), an American was paid four times as much as an Arab or an Indian or a Pakistani. This immediately aroused professional jealousy and dissatisfaction. I found this distasteful enough that I decided Saudi Arabia was not a country where I would wish to make a permanent home, because there was such blatant discrimination between individuals, and I was being treated inferiorly on account of my coun-

try of origin rather than because of my professional expertise, competence, or work output.

Finally, I arrived in America in the 1970s. I was very impressed by the high standard of medical care provided to the patients, in and out of the hospitals. Tests that were unavailable in England unless you were at a referral center were available even in suburban areas and county hospitals. It was a high-tech environment, and the technology was available to most patients, even in remote areas. When I arrived, the cost factor had not yet kicked in, and waste was abundant. Duplication and redundancy were commonplace, and there was no regard for the cost of a particular medicine, instrument, procedure, modality, or investigation. Hospital stays were prolonged, and inpatient treatment was being given for investigations that could be easily performed on an outpatient basis. No wonder all this kept escalating the cost of care, until it became a national issue. It was then in the 1980s that the cost cutting started. The first to go was the inpatient stays for outpatient type of investigations, and there was encouragement for one-day surgeries. Then came clearances from insurance companies for investigations and implantation of devices (like pacemakers, total hip replacements, etc.). Finally, we began doing same-day admissions for procedures, even major ones such as coronary bypasses. Now, the doctors often have to endure clinical hardship by having them constrained by the whims and requirements of insurance carriers and especially the relentless health maintenance organizations (HMOs). The final straw was the establishment of HMOs, which set their goals on cost containment, even at the cost of denial of care. I remember several malpractice suits where the doctors stated that they were forced to deny care because of HMO insurance carrier policies.

Rising health care costs, the lack of regulations of the health care insurance companies that would prevent them from denying coverage for certain individuals or for pre-existing disease, and the increased number of individuals at or just at above the poverty level led to the emergence of a large segment of the population, probably about 45 million, who lack health care coverage.

At the turn of the millennium, we have seen doctors' reimbursements reduced drastically. I have personally witnessed young doctors, especially surgeons, having to close their practices and go out of

business as a result of excessive overhead, mounting malpractice rates, and reduced reimbursements. Some doctors have had to change their specialties, and some even had to change their professions. (I have heard of a cardiovascular surgeon becoming a vein specialist and a surgeon becoming a real estate agent.)

Thus, the delivery of health care has now become a national concern. Our new young and energetic President Obama has aimed to correct the system where everything seems to be going in the wrong direction. According to his speeches “We need a complete overhaul of the health care in America!”

On July 14, 2009, some members of the U.S. House of Representatives introduced House Resolution 3200, America’s Affordable Health Choices Act of 2009. Some of its goals include:

1. Universality of care, an effort to reach the 40-45 million Americans who have no health insurance.
2. Affordability of care, as the premiums have continuously escalated, doubling and tripling in recent times.
3. Delivery of care: Care has to reach remote and underserved areas.

Unfortunately, not much mention has been made of the much-needed malpractice and tort reform.

In addition to these important goals, we Muslim physicians perhaps should advocate for the addition of spirituality in medical care. IMANA can be in the forefront of these much-needed changes, for the sake and welfare of American medicine. With the leadership of our association being entrusted for the first time in the hands of a native-born American Muslim physician, I can foresee great changes ahead in IMANA. The first and foremost is Muslim physicians’ involvement in the American health care policy discussions, especially the political and legislative process. Instead of us being helpless onlookers of the scene, as many of the first-generation of immigrant American Muslim physicians have been, we need to be involved in changing the scene. IMANA needs to be involved in the debate about health care reform and to try to correct what is wrong with American medicine. Also, the broadening of our visions and frontiers needs to include serious thinking of formation of the first Islamic hospital, university, and medical school in the United States. More than that, I can only hope and pray to Allah ﷻ that one day the

compassion of Islam and other religions will find its way into the delivery of medical care, not only in America, but in the rest of the world.

I close with a few words about the first Islamic hospital, medical school, and university in America. This can become a quick reality. It can be achieved with a combination of the American Muslim entrepreneurship of young Muslim business people, doctors, lawyers, and the vast Muslim capital net worth that presently lies unharnessed. If all of these resources are pooled, one successful model can be created. It would be a recipe for instant success. The hospital should be in a large metropolitan area with a substantial Muslim population (Detroit, Chicago, New York, or Los Angeles), where it can be sustained financially and should become the epitome of compassionate care for the rich and poor alike, sending a message to the world that Muslims do care for all humans, irrespective of their race, religion, color, caste, or creed. Pioneers and visionaries such as the late Dr. Ahmed El-Kadi (rahimahu Allah) started the Muslim al-Akbar clinic in Panama City, Florida, in the 1970s. Unfortunately, it did not succeed because it happened at the wrong time and the wrong place. The milieu is entirely different now.

With this plea, I urge every Muslim physician to become an active part of IMANA by becoming a life member. We estimate that we have 35,000 to 45,000 Muslim physicians in the United States. Imagine the force that we can generate if we unite under one umbrella? That would be a force that could alter the future of medicine in America and the rest of the world forever. May Allah help us to achieve these goals.

Wassalam,

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