What price commitment?

Point/counterpoint

What price commitment?

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The late Alexander Walt, MD, FACS, referred to medicine as the "most noble profession." I agree and believe two of the most important fundamental characteristics of medicine are our ethical heritage and personal commitment to the profession. I would like to briefly examine both of these foundations of our profession.

The first written promulgation of physician ethics is more than 3,500 years old. Various renditions were developed subsequently, but the similarities between them are remarkable. The first physician oath, taken by Hindu physicians, is as follows:

> You must be chaste and abstemious, speak the truth, not eat meat; care for the good of all living beings; devote yourself to the healing of the sick even if your life be lost by your work; do the sick no harm; not, even in thought, seek another's wife or goods; be simply clothed and drink no intoxicant; speak clearly, gently, truly, properly; consider time and place; always seek to grow in knowledge. Do not treat women except their men be present; never take a gift from a woman without her husband's consent. When the physician enters a house accompanied by a man suitable to introduce him there, he must pay attention to all the rules of behavior in dress, deportment, and attitude. Once with his patient, he must in word and thought attend to nothing but his patient's case and what concerns it. What happens in the house must not be mentioned outside, nor must he speak of possible death to his patient, if such speech is liable to injure him or anyone else. In face of gods and man, you can take upon yourself these vows; may all the gods aid you if you abide thereby; otherwise may all the gods and the sacra, before which we stand, be against you; and the pupil shall consent to this, saying, "So be it."[1]

Among the subsequent oaths, only one refers to physician reimbursement. This quote comes from the first known formal pledge of medical ethics among the Jews: "Do not harden your heart against the poor and the needy; rather have compassion upon them and heal them."[2]

According to the *Oxford English Dictionary*, commitment means, "To give to someone to take care of, keep, or deal with; to give in charge or trust, consign to." In a sense, physicians have a dual commitment: one to our patients and another to our profession.

It is my perception that these two cornerstones, ethics and commitment, are being assaulted by external forces. Unfortunately, I worry that within the profession these values are eroding as well.

Medicine as business

In *Time to Heal: American Medical Education from the Turn of the Century to the Managed Care Era,* Ludmerer states that medicine has become a business.[3] I have previously commented on this trend,[4] but I will repeat a summary of why he be-

lieves medicine has become a business and how this development has led to our current health care crisis.

In the 1950s and 1960s, the National Institutes of Health expanded its research dollars, which in retrospect may have been detrimental in two different ways. First, this growth allowed medical school faculties, particularly in nonsurgical specialties, to expand and even double or triple without a concomitant commitment to teaching or supervised patient care. The second adverse effect is paradoxically a result of our success: knowledge derived from research has spawned expensive diagnostic and therapeutic modalities.

The second seminal change in American medicine after World War II was the passage of the 1963 Health Professions Educational Assistance Act, with additional bills in 1965, 1968, and 1971. This led to an increased number of medical schools and expansion of medical school class sizes. Lewis has postulated that the subsequent proliferation of physicians has paralleled and, indeed, caused the increased costs in medical care.[5] Cooper has challenged this concept, arguing that we are now facing a physician shortage.[6] Nonetheless, he does concur that the physician costs of medicine continue to rise despite an increase in the number of physicians.

The third force affecting increased costs was the passage in 1996 of Titles XVIII and XIX of the Social Security Act. The elderly and some of the indigent were now covered by health insurance, and academic health centers (AHCs) again increased faculty sizes.

Then in the late 1980s, the cost of medicine reached crisis proportions for the business community. It was argued that "there is more health care than steel in a Chevrolet." The business community responded by embracing fierce price competition among insurers who then proposed externally "managed care" to physicians and hospitals.[7] This solution was championed by the Clinton Administration at the 1993 Jackson Hole Conference. Ultimately this proposal failed, due in no small part to omitting from the planning process the very provider groups that would care for the patients. Nevertheless, managed care survived, albeit on life support, and was inflicted on an unsuspecting public and academic health community.

As a defense, AHCs adopted corporate strategies to cope with market forces, and began losing sight of their basic mission. As a result, we sacrificed our special place in society.[8] Some of the strategies that have developed are depicted in Table 1, above. It is noteworthy that none of these strategies would improve patient care or enhance a scholarly environment. I reluctantly am forced to conclude that Ludmerer is right—medicine has become a business, and this change creates an ethical dilemma. It also makes me worry that I am no longer playing for the same team that I signed up to play for in medical school.

Table 1

Strategies by AHCs to cope with health care reform

- Reduction in residency size
- Integrated delivery systems
- Limitation of tenure
- Aggressive marketing and advertising
- Hospital "consortia" for GME
- Increase patient volume
- Increase market share
- Seek new sources of income
- Managed care initiatives
- Redesign faculty practice plans
- Increase primary care
- One plan for the entire school
- Hospitalists and intensivists
- AHC consolidation

Business ethics

The evolution of ethics in business began in the Renaissance. Descartes postulated that observation was in doubt—the so-called methodical doubt. He proposed to reduce all concepts to their fundamental mechanistic terms, thus leading to "reductionism." The economists of the day were not to be left out of this scientific scrutiny. John Locke said, "The great and chief end, therefore, of men's uniting into commonwealths and putting themselves under government is the preservation of property." In Locke's view, the preservation of property was devoid of a set of ethics that pro-

tected the peasants from the landowners. Subsequently, Dudley North thought that it was best in business "to leave things alone to seek their own natural balance." Ultimately, it was Adam Smith, in *Wealth of Nations,* who espoused a "natural law" in which self-interest itself served to protect each of the parties, including capitalist, producer, laborer, and buyer.[9]

In 1989, Lawrence Shames published *The Hunger for More: Searching for Values in an Age of Greed.*[10] This book fundamentally and enthusiastically condemns the ethics of business. He states, "In terms of moral categories as old as the Bible and as central to Western Civilization as Aristotle, there is no such thing as business ethics, anymore than there is such a thing as sports ethics or leisure ethics or sex ethics. There's only one ethics, and it applies to all aspects of life." He then documents multiple examples of greed and flawed ethics within the business community. Recently, his position has been persuasively corroborated and updated on the Internet.[11]

Shames concludes, "Business ethics was rife with givens. The sanctity of profit was, of course, a given. Not just the reality, but the legitimacy of human avarice as a motivator, was also a given. Inequality was a given, since Darwinian competitiveness was a given, and on the savannah of business, there would always be winners and losers, predator and prey. Even a certain amount of criminality was a given; no one expected universal virtue in a domain where success was defined solely by the rewards of success, where accomplishment was judged by counting."

Although the book was written in 1989, it was prescient of our current corporate scandals. Shames further concluded, "Everything would not be all right, since the problem at its most fundamental, was not one of mere greed, but of an awful want of respect for the rules, for each other and for ourselves. Cheating in business was one expression, but not the substance, of that lack of regard. Wealth, where it was dubiously acquired, became a measure of our content, a way of thumbing our noses at a system that could make us prosperous but not exalted."

I maintain that as medicine has progressed into a business, we are starting to experience a similar decay in our medical ethics. Can we avoid this turn of events? Is there an alternative?

Table 2

Compensation: Academic surgeons

Average couple/two children	$60,000-90,000
Invasive cardiologist	$325,754
Gastroenterologist	281,308
Orthopaedics—foot and ankle	345,713
Orthopaedics—spine	515,277
Orthopaedics—trauma	370,824
Neurosurgeon	457,919
General surgery	245,541
General surgery—trauma	297,150
Urology	304,547

Source: Medical Group Management Association, 2001.

Table 3

Compensation:
Private practice after eight years

Interventional cardiologist	$405,000
Gastroenterologist	301,000
Orthopaedics—foot and ankle	418,000
Orthopaedics—spine	651,000
Neurosurgery	450,000
Cardiac surgery	536,000
General surgery	251,000

Source: Medical Group Management Association, 2001.

Medicine—public good

Permit me to put medicine into economic perspective and then examine the evolution of physicians' income over the last century. From a microeconomic standpoint, I want to believe medicine is a public good. A service is defined as a public good if has the attributes of nonexclusivity and noncompetitiveness.[12] Nonexclusivity obligates access—individuals cannot be excluded from benefit. In the U.S., health care is implicitly rationed and access is unequal. A good is noncompetitive if consumption of additional units of the good involves zero social marginal costs of production.

Medicine has been compared to national defense and the fire and police departments, which are also public goods. Many economists argue that efficient provision of public goods ought to be accomplished free of charge. While access to emergency care and a disease-free society benefit everyone, medicine is at least partly rivalrous in consumption, and, thus, it is not a pure public good.

A corollary to medicine as a public good is whether physicians who handle emergencies should strike. Police officers, firefighters, and soldiers are prohibited from striking. Recently, surgeons went on strike in several states. Is this activity reflective of commitment to our patients?

In 1900, a physician's annual income, at $750 and $1,500 a year, was slightly below the national workforce average.[13] In 1928, it averaged $6,354, but fell in 1929 with the Great Depression to $3,758. In 1945, it was $8,000, and in 1969, it was $32,000. In contrast, in 1998, the average primary care physician made $139,244 and a general surgeon, on average, made $225,653.[14] To put this in perspective, in 1900, physicians were considered to be in the lower middle class, whereas now physicians make four to 10 times the national income average, depending on their specialty. More recent examples for specialty surgeons' and physicians' income are shown in Tables 2 and 3, page 11.

Adverse external forces

Paralleling the erosion in the perception of medicine as a public good has been a decrease in government support for academic health centers. Medical schools have responded to this problem in several ways. First, in many schools, tuition has increased (Figure 1, this page), which has increased student debt and may have frightened young physicians into a destructive focus on finances. Second, the hospital has become the revenue engine that supports the administration of the health center and the school of medicine. To enhance the revenue stream, hospital administrators have targeted surgeons, particularly specialty surgeons, to attract patient volume and dollars. Surgeons are encouraged to spend more time in the operating room at the expense of scholarly activity. Third, AHCs are recruiting niche surgeons to establish high-profile lucrative programs. To recruit these boutique practitioners, the academic reimbursement model has been abandoned,

Figure 1

Increase in tuition at Oregon Health & Sciences University

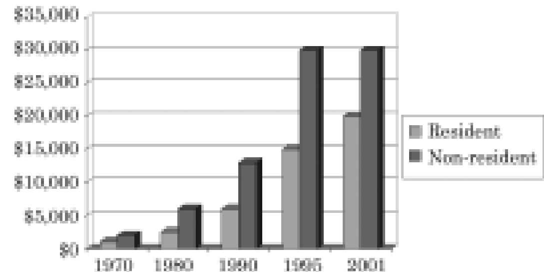
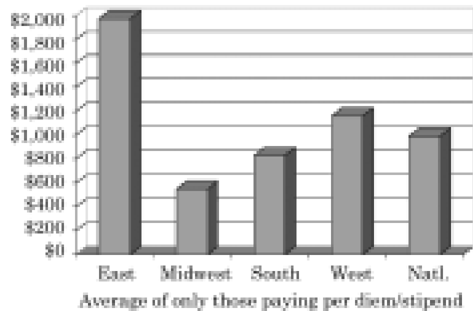


Figure 2

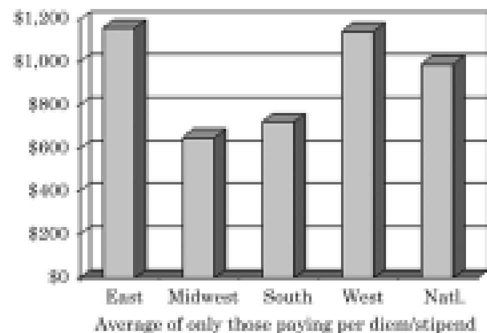
Orthopaedist daily on-call pay by region



Source: Bishop and Associates, 2002.

Figure 3

Neurosurgeon daily on-call pay by region



Source: Bishop and Associates, 2002.

and, in its place, we now have the "professional athlete model." This has escalated some specialty surgeons' annual income into the obscene stratosphere and confirms the cynic's view that "annual income relates inversely to community service."

Negative internal forces

Adverse forces are assaulting both ethics and commitment from within the profession. Permit me two examples: On-call pay and freestanding ambulatory surgery centers.

In the last century, it was common for the medical staff to provide call either in their specialty or for the emergency room. The so-called Pontiac Plan required all doctors to take their turn in the ER with few exceptions. This plan proved inadequate, and in the early 1960s, emergency medicine developed as a specialty. Since then, emergency care has been provided in most hospital emergency rooms by members of this specialty. In the late 1960s, trauma systems were developed, and as part of that program, the general surgeon in the level I and II hospitals often took call in-house or had to be immediately available. Blunt trauma became the predominant cause of injury, but only 12 percent of these cases required surgical intervention. The primary roles of general surgeons became resuscitation and critical care, which are not adequately reimbursed. This necessitated hospital administrators to subsidize the trauma service through annual support dollars (administrative stipends) or on-call pay, particularly when the surgeon was in-house. Simultaneously, it became necessary for anesthesia to stay in-house to care for trauma, emergency surgery, and obstetrics.

In the past three to four years, a different pattern has evolved, with specialty surgeons asking to be paid to take call at home. Although regional differences exist, the demand for this at-home call compensation varies

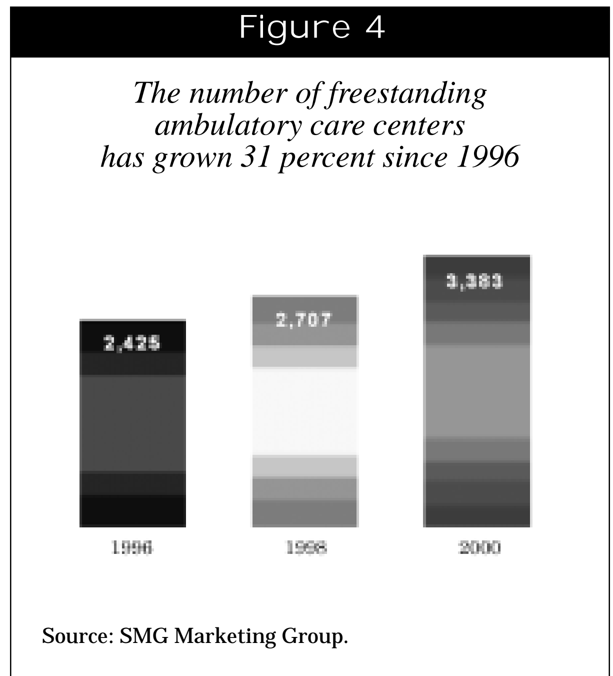


Figure 4

The number of freestanding ambulatory care centers has grown 31 percent since 1996

Source: SMG Marketing Group.

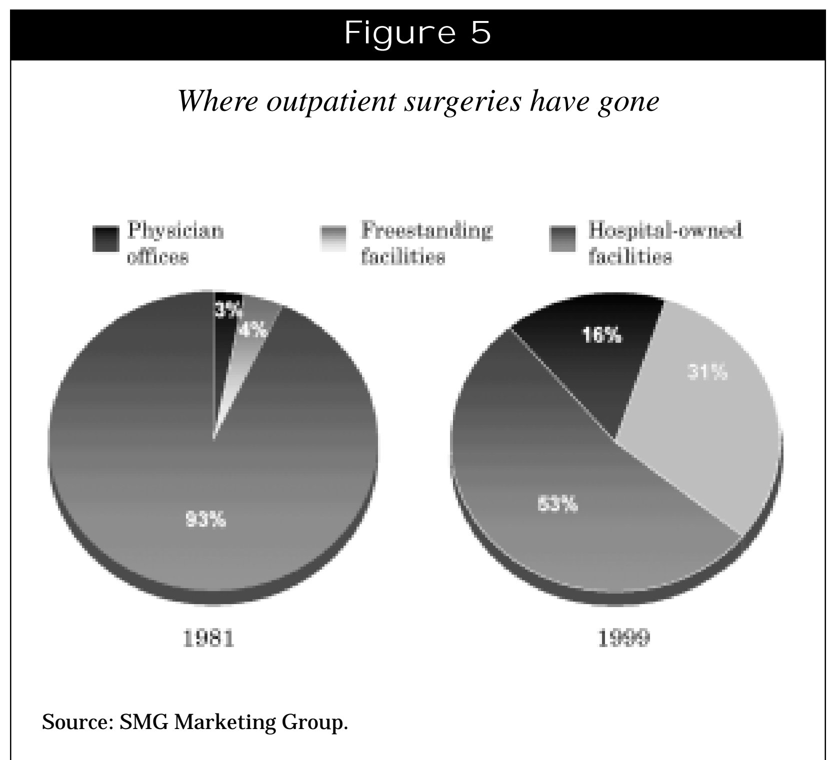


Figure 5

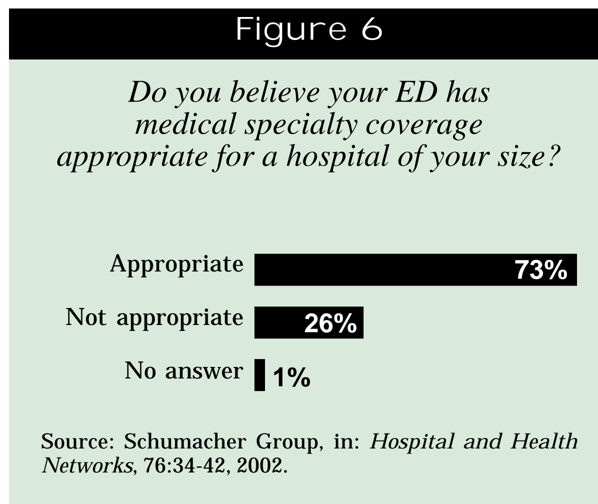
Where outpatient surgeries have gone

Source: SMG Marketing Group.

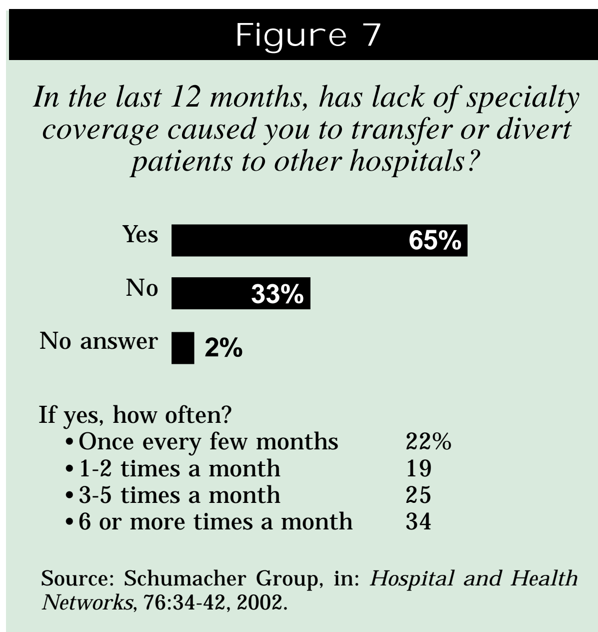
from $1,000 to $2,000 per night. The rationale for this on-call pay has been justified by one of the specialty surgery organizations.[15] As far as I know, this policy constitutes a precedent in the relationship between medical staff physicians and hospital administration. The incremental costs on an annual basis to the health care budget of the U.S. are considerable. Assuming a minimum of 1,000 level I and II trauma centers, the annual cost of on-call orthopaedic and neurosurgery ($2,000 each/night) would be $1.46 billion. (See Figures 2 and 3, p. 12) But most general surgeons, neurosurgeons, and orthopaedic surgeons do not want to take trauma call.[16] The reasons for this reluctance include poor reimbursement compared to elective operative cases, disruption of the next days' elective schedule or office practice, a perceived increase in malpractice liability, and impairment of lifestyle. Isn't this behavior also evidence of a lack of commitment?

The second example is freestanding ambulatory surgery centers. Paradoxically, these centers do reduce costs compared to hospitals and may provide better service/convenience to the patient. However, there is potential secondary gain for the surgeon in these centers. Since 1996, the number of these ambulatory surgery centers has increased from 2,314 to 3,383 (see Figures 4 and 5, p. 13). Half of these ambulatory surgery centers are owned by corporations, one-fourth are limited partnerships, and the remaining one-fourth are a combination of partnership and sole proprietorship. Since 1996, the volume of surgical cases in these centers has increased from 4.3 to 7 million per year. The incentives for surgeons to join these groups include a perceived increase in income (particularly for the surgeon owner or part-owner), no night call, no Emergency Medical Treatment and Active Labor Act (EMTALA) requirements, and an improved lifestyle. Many of these centers accept only patients with commercial insurance, excluding Medicare, Medicaid, and indigent patients.

This prerequisite has a double negative effect. It accentuates the double-access standard of care with a destructive rebound on the traditional general hospital. By skimming the payor cream off of the top of the insurance dollar container, it aggravates the ability of the acute care hospitals to cost shift for government-insured patients and the indigent. It may also impact negatively on the availability of general and specialty surgeons in trauma centers (see Figures 6 and 7, above.)



Source: Schumacher Group, in: *Hospital and Health Networks*, 76:34-42, 2002.



Source: Schumacher Group, in: *Hospital and Health Networks*, 76:34-42, 2002.

I believe these two examples of negative internal forces are uniquely troublesome. They parallel the ethical flaws that have recently flourished in our business community. Greed and a lack of commitment to our patients have contaminated the medical profession.

Definition of "profession"

An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members profess a commitment to competence, to integrity and morality, to altruism, and to the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which grants the profession the right to autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society. (Derived from the *Oxford English Dictionary* and the literature on professionalism.)

Perspectives

Clearly, not all businesspeople (CEOs and CFOs) are greedy or corrupt. Indeed, most are socially responsible and contributing citizens. Similarly, the majority of physicians serve their patients and their profession admirably and are not driven by greed. However, as in all walks of life, some physicians sully our profession. I believe that we must address these issues and find solutions, or we risk (and deserve) the scorn and condemnation of our patients and the public at large.

Let us assume (and I want to believe) that the economists are right: medicine is a public good. As such, we are the only example of a public good where professionals have the privilege of receiving fee-for-service payment. In contrast to physicians, police officers and firefighters work shifts. In many police departments, if there is a pay differential, it is very nominal. Many police departments also have a fairly rigorous on-call protocol under which any police officer may be called back for an emergency. Firefighters typically work 24 hours and are then off for 48 hours. I propose that the fee-for-service application to a "public good" is quite fragile and is a privilege.

It is an inescapable fact that medicine as currently provided must stand on its own financial feet; hence, it is a business. Disease and injury are inevitable and health care represents 16 percent of our gross domestic product. Physicians are a small part of the total labor/professional component of the health care industry. In a very real sense, we are a profession within a business. The nonphysician administrators of the health care business (insurance executives, hospital administrators, administrators within clinics, nursing homes, and rehabilitation facilities) may not appreciate the uniqueness of medicine's relationship to our community and to the patients we serve. In fact, as shown in Table 1, their solutions to health care reform are predictable, approached from a business perspective, and their recommendations to bolster profit do not always take into account what is best for the patient. Nevertheless, within the medical profession, it is imperative that we adhere to the ethics of our profession and maintain our commitment to our patients.

Our colleagues within the business community are making a gratifying effort to reform "the world of problems caused by greedy corporate executives."[17] A "watchdog" organization called the Conference Board's Commission on Public Trust and Private Enterprise has been created by concerned business leaders, including Mr. Warren Buffet. They want stricter rules on stock options and strong oversight by corporate boards over executive pay. This pay should be linked to long-term company performance. The group also recommends that companies charge stock options as an expense, whereas others recommend doing away with this "perk" altogether.

I assert that we need a similar group within our national organizations to provide oversight/recommendations on the ethics and business components of medicine. This oversight committee must recognize the unique requirements of an academic health center in teaching values and ethics to health professionals. Committee members should include individuals representing academic medicine and should be drawn from organizations such as the American Association of Medical Centers or the Institute of Medicine.

I further believe that professional organizations,

such as the American College of Surgeons, must address greed within the profession and identify lack of commitment. How much is a physician worth? In the past, many professional societies have refused to address this issue. When (not if) our country adopts a single-payor health care system, will professional organizations continue to ignore this issue? Will the professional societies become "unions for professionals?" Would it not be better for professional societies to establish rules or recommendations on night call in the hospital or at home? Should all surgeons participate in this call, or just the ones who work in large health centers?

Finally, I believe the College and other professional organizations must take a firm stand in academic health centers to protect that which is noble and right about medicine. There will be inevitable conflicts between the business of medicine and the values of medicine. How can one teach the ethics and values of medicine if one does not practice them? Under our current health care paradigm, 40 million Americans do not have equal, comfortable access to health care. The public expects doctors to provide charity care; if we do not, we have abandoned our principles and sacrificed our ethics to "business." Our professional societies can and must serve as effective "watchdogs" for our profession. Ω

References

1. Strauss MB (ed): *Familiar Medical Quotations.* Boston, MA: Little, Brown & Co., 1968, p. 325.
2. ben Berachian A, ben Zabda J, in: Strauss MB (ed): *Familiar Medical Quotations.* Boston, MA: Little, Brown & Co., 1968, p. 326.
3. Ludmerer KM: *Time to Heal: American Medical Education from the Turn of the Century to the Managed Care Era*. New York, NY: Oxford University Press, 1999.
4. Trunkey D: Impact on the new chair. *Arch Surg,*136:165-168, 2001.
5. Lewis FL: Trauma 2000: Challenges for the new millennium. *J Trauma,* 50:185-194, Feb. 2001.
6. Cooper RA, Getzen TE, McKee HJ, Land P: Economic and demographic trends signal and impending physician shortage. *Health Aff,* 21(1):140-154, 2002.
7. Reinhart UE: Academic medicine's financial accountability and responsibility. *JAMA*, 284:136-138, 2000.
8. Schroeder SA: A saga of "paradise lost." *Health Aff*, 19:256-257, 2001.
9. Burke JA, Orstein R: *The Axemaker's Gift*. New York, NY: Penguin Putnam, Inc., 1997.
10. Shames L: *The Hunger for More: Searching for Values in an Age of Greed*. New York, NY: Times Book, 1989.
11. Web site: http://www.ex.ac.uk/~RDavies/arian/scandals/classic.html, accessed September 6, 2002.
12. Nicholson W: *Microeconomic Theory: Basic Principles and Extensions*, 5th edition. Fort Worth, TX: The Dryden Press, Harcourt, Brace, Jovanovich College Publisher, 1992.
13. Starr P: *The Social Transformation of American Medicine*. New York, NY: Basic Books, 1982.
14. Medical Group Management Association/Academic Practice Compensation and Production Survey for Faculty and Management, 2002.
15. McVicker J: Neurosurgical contracts with trauma hospitals. AANS/CNS Section of *Neurotrauma and Critical Care Newsletter*, Spring 2001.
16. Esposito TJ, Maier RV, Rivara FP, Carrico CJ: Why surgeons prefer not to care for trauma patients. *Arch Surg,* 126(3):292-297, 1991.
17. Brown K: Another panel targets executive pay. *Wall St J*, Sept. 17, 2002.

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