

“Laying on of the hands”



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Anyone who hasn't been asleep for 25 years, Rip Van Winkle-like, knows that medicine has an image problem. Physicians often are seen as arrogant, uncaring, out of touch, too wealthy, and uninterested in the welfare of their patients. To the majority of physicians who are genuinely interested in the well-being of their patients, and to whom they seek to provide excellent care, this perception is deeply troubling. Yet, despite the efforts of individual practitioners to provide the best care under increasingly difficult circumstances, most Americans believe that organized medicine is not interested in the patient.

Furthermore, surgical leaders sometimes perpetuate our negative image. For example, I recently attended a meeting in which a discussion of electronics and the practice of medicine transpired. In that session, an officer of a major medical organization suggested that physicians communicate with their patients by e-mail to enhance physician-patient interaction.

While I have the highest regard for that physician's intellect and leadership qualities, I believe that in this case, he has gotten it all wrong—wrong by encouraging a personal detachment and disembodiment from patients. This proposal, in my view, is the ultimate evolution of the so-called medical leadership's views of the academic medical center, which has gotten us into the trouble we in medicine have been in over the past few years. This attitude, I believe, has led us astray.

The various organizations representing the leadership of academic medical centers, teaching hospitals, and colleges of medicine have developed a stance in which research is now touted as the be-all and end-all, manifest by the tyranny of where that institution is on the list of federal grant holdings. Contact with patients is de-emphasized, patient care is de-emphasized, and service to patients is not a priority. Taken to its logical extreme, e-mail communication with patients, those few that the academic medical center would retain under such circumstances, would represent the ultimate disconnection from patients—a disembodied contact in which the physician would never have to see the patient. Thus, research would triumph, as e-mail messages could be done after hours or at times that are less convenient for research. As you may have gathered, this prospect sorely troubles me. It emphasizes and confirms to me that the lead-

ers of academic medicine in this country really do not understand that medicine has been thoroughly degraded over the past 10 to 15 years, that the profession is no longer considered capable of regulating itself, and that the public has turned its back on us.

Yet this degradation and the public's scorn does not extend to all aspects of care. Alternative medicine, herbatology, homeopathy, massage therapy, aromatherapy, indeed even chiropractic care, are flourishing, and the public is willing to go outside of the insurance system and pay "first dollar in" (charges, not discounted) to these individuals. Indeed, a number of physicians have turned their backs on the insurance system and accepted patients on a cash-only basis. For those who can give the time to patients, they indeed are flourishing as well.¹ Has it ever occurred to the leadership of the American academic medical community to ask why, in the face of the destruction that reimbursement reductions have wreaked on the academic medical center, these previously controversial forms of medicine are flourishing and patients are willing to pay the agreed-upon fees to their practitioners? Is it possible this trend merely reflects that what the public really wants, and what physicians have traditionally offered, is "laying on of the hands," a practice not encouraged by our medical schools?

The lack of "laying on of the hands" is unfortunately widespread. Contrast, for example, the great painting "The Doctor" by Sir Luke Fildes, which shows a physician at bedside during the Philadelphia yellow-fever epidemic (see opposite page). The physician, shown in a caring mode, could obviously do very little for his young patient, who may very well have died. However, he was there, and he "laid on the hands." Contrast this with the current procedures in approximately 50 percent of family practice clinics, the mode of practice currently championed by most deans of academic medical centers in which the physician is never seen, and a nurse practitioner or a physician's assistant is the only one who sees the patient. While the care may be equivalent, and there is evidence that it is, is this why we went to medical school? Is this laying on of the hands? What have we come to?

It is constructive to harken back to 1913 when, in the formation of the American College of Surgeons, Franklin Martin had as two of his basic tenets that "ghost surgery" and fee-splitting were

eschewed by the College. Was this not a manifestation of the face-to-face relationship with the patient, in which laying on of the hands was not only proposed but championed?

The unfortunate trend toward disembodiment of health care has been long in coming. One of the vice-chairs of our excellent faculty, Henry Neale, MD, FACS, chief of the division of plastic surgery and former chair of the American Board of Plastic Surgery, recently brought to my attention a speech by William A. Altemeier, MD, FACS, his former chief, my predecessor, and a Past-President of the American College of Surgeons, warning against the conversion of the practice of medicine to a business.² What is interesting is that this presidential address to the Society for Surgery of the Alimentary Tract was published in 1974.

Despite the fact that we are looking at the results of a problem that has been building for several decades, there is an opportunity here. Lest you believe that I have taken leave of my senses, let me outline it.

The death of managed care

I believe “Phase I” managed care is dead. While some of my faculty think this theory is delusional, it is not my original observation but that of highly respected individuals in industry whose refusal to pay for the rapidly increasing costs of health care actually triggered the managed care revolution. Contrary to their own gut-wrenching applications of quality in the 1980s and 1990s, which were win-win with “everyone” profiting (except for the millions who were found redundant and lost their jobs), they point out that managed care creates a win-lose situation, with redistribution of income from physicians to executives, and from bedside to overhead and profit, as well as huge bonuses paid to executives.³

This scenario is not what industry envisioned when it promoted managed care. Now, not only is the public angry, but the sponsors of Phase I managed care are surrounded by irate employees who decry the lack of availability, the insufficient time physicians spend with them as they are forced to make up their quotas of seeing patients. Additionally, there is the lack of capital for newer advances in patient care on the part of both hospitals and physician practices and the outrageous bonuses awarded to executives whose incentives seem to be

decreasing access and denying services (rationing—the “R” word).

Is health care a privilege or a right?

It is interesting that in the previously cited *New York Times* article,¹ Uwe Reinhardt, PhD, the entertaining and widely quoted Princeton University economist, points out that with the Internet revolution, physicians will be punished for lack of quality, and therefore, physicians are trying to turn back the clock, an effort he says will not work. Ethicists, whatever their credentials, seem to agree with Professor Reinhardt’s pronouncements. I, however, believe Professor Reinhardt is probably wrong, as wrong as he was about managed care being the answer to this country’s health care problems. Indeed, I think he misses the point.

In the 1960s, after prolonged debate, it was decided that health care was not a privilege, but a right. At that point, with the growth of the welfare society promoted very effectively by President Lyndon Johnson, Medicare and Medicaid were instituted, providing a safety net for the elderly and the indigent, two groups of traditionally underserved patients. While not all underserved patients were covered by these initiatives, the majority were. The focus was on quality health care for all—perhaps not the amenities, such as private rooms, but supervision and access to first-rate care. Most in the medical profession agreed with this initiative. Others warned that accepting the federal dollars would ultimately lead to government regulation. Indeed, this argument proved prophetic.

Between the 1960s and the present, the skyrocketing costs of health care, well in excess of inflation, led industry to join with the Left to mandate managed care. The business community and the country decided it simply did not want to pay for the increasing costs of health care. Thus, the Right joined with the Left to begin the systematic degradation of the medical profession. Simply speaking, medicine, under the guide of the New Age economists such as Professor Reinhardt, became a commodity to be traded by business, the unions, and the government.

Quietly, as the 1980s evolved, the perception grew that quality health care was no longer available to everyone, nor, indeed, was it available even to those people who thought they were paying for it. Thus,

quality medicine, the mantra of the 1960s, was no longer viewed as extant, and because people believed quality medicine was no longer available, the country almost without debate abandoned the concept of health care as a right and not a privilege.

I am rather surprised at Professor Reinhardt, because he is the individual most closely identified with the concept of three class tiers in the U.S. economy and society. While a simplistic concept and one that does not cover all individuals, it has some merit, if only for discussion purposes. According to this paradigm, the upper class, the top 1 to 5 percent, live in gated communities, purchase their own security, pay for their own garbage collection, send their children to private elementary and high schools and then to Ivy League colleges. In health care, this segment purchases whatever they want. The middle class live in the suburbs and exurbs with sympathetic police forces, public garbage collection, and fire protection. Their children go to good to excellent public schools and attend, for the most part, private or state universities. Their health care is restricted, with managed care unhappily providing the major share. The urban poor, the permanent underclass, now approaching fourth-generation dependency, experience a total breakdown of family, attend unresponsive public schools in the grip of teachers' unions that stoutly resist any attempt to measure quality, rarely graduate from high school, face a hostile police force and indifferent garbage collection, and for medical care, take what's left over. I fail to understand the inconsistency in Professor Reinhardt's thinking, since the current state of medical care is perfectly consistent with the three communities he envisions for the United States.

In any event, the utopian concept of quality health care for all has disappeared as an unforeseen side-effect of the attempt at economies in health care and without the noble vision of quality health care for all—health care as a right, not a privilege.

The opportunity

The business community recognizes that Phase I managed care is a failure. Indeed, so do the legislatures. In at least 23 states, some type of patients' rights bill has not only been proposed but passed.

In July 1999, for instance, Ohio passed a patients' rights law that includes an external review system, and, undoubtedly, before long will include some ability to sue managed care companies. Congress is now debating national patients' rights legislation, and it is likely that at least some limited ability to sue managed care companies will result despite the extraordinary lobbying efforts by the insurance companies and their associations. Legislatures follow, they do not lead, and they clearly want to improve a health care system increasingly viewed as having gone awry. Thus, this intense interest in improving quality health care, however misplaced, utilizing the tort and malpractice system, seems inevitable.


The opportunity awaiting us is fairly simple and straightforward. Business understands that unless it can duplicate the win-win situation that it pioneered with its quality movement in the 1980s and 1990s, health care will not improve, and businesses will not experience an adequate return on what they are paying. Our traditional answer to the plea by business for someone to partner with them in trying to identify "quality" has been the traditional guild response: "We do not know how to measure quality; we do not think we can; and we will not join with you in an attempt to identify it." Industry asks us questions, such as why the rate of hysterectomy in one U.S. county is 400 percent that of an adjacent county. Our response—that this is the art of medicine, and it cannot be fathomed, as if this is some Delphic oracle mystery—does not strike a responsive chord.

I believe it is time organized medicine, the College first and foremost, take the lead in trying to identify best practices and to partner with business in an attempt to identify quality and base medical practices on our concept of quality. Quality means output over cost. Hopefully, we can partner with business in an attempt to achieve the same or improved output or patient care at a lower cost by resorting to best practices. Having done this a number of times in our own institution by applying best practices by consensus, it is clear that this can be done with some work on the part of medicine, nursing, and hospital administration with substantial savings.^{4,5} We also need to partner with business in attempting to move them from focusing on the single episode to the long-term costs of health care. Since half of the costs of

health care are estimated to occur in the last six months of life, for example, in malignant disease, wouldn't it be possible to get business to focus on best practices for diseases such as carcinoma of the colon, and estimate lifetime costs and the true savings of best practices? I believe that industry would jump at the chance if they conceive that they had someone responsible with whom to partner.

This is the time to open dialogue with business. We need to tell them we are not certain we can measure quality, but we will attempt to help them identify it, however long and convoluted this attempt may prove. We must demonstrate that we will partner with them in promoting best practices, and when we do not know what best practices are, conduct clinical trials and patient-oriented research in an effort to identify them. I am hopeful that business will join with us and even pay for such research if they correctly perceive that this may save them money in the long run. If we can get them focused not on the single episode, which is inimical to most physicians, but on their expenditures on long-term outcomes, and to identify quality as output over cost, everyone will win. Indeed, with their concept of win-win situations, ultimately we will probably be paid more because they feel that this is an essential component of joining with medicine to improve quality.

In addition, if we do this, we can return to our historical role as advocates for the patient. This is one of the principles upon which the College was founded, and remains one of the principles that all surgeons, who in the best sense are physicians who operate, have championed.

To some, these proposals may seem Pollyannaish. Even so, I personally find the prospect of returning to our established values very exciting and look forward to the day of partnering with industry so physicians can do what they have always done best—advocate for their patients, “lay on the hands,” and lend advice and comfort. I look forward to medicine being restored to a profession of which we can be proud and to which we can attract our sons and daughters, advocating our profession to them. That prospect I find particularly exciting. 

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