

The physician, patient, and third party

by Oliver H. Beahrs, MD, FACS, Rochester, MN

The American College of Surgeons was established by Franklin H. Martin and his Chicago associates in 1913, for the most part, to improve the quality of care of the surgical patient and the quality of the operating room environment and to advance the science of surgery. All of these goals were endorsed and supported by the Mayo brothers and the institution with which I have been associated during my surgical career.

Its founding, however, was surrounded by controversy within the medical profession. Outspoken critics in the profession said that the College was being organized strictly for the financial gain of those who could put "FACS" after the MD following their names. This attitude is well described in the book, *Fellowship of Surgeons*, by Loyal Davis. Today, 75 years later, the echoes of financial matters have once again become the main theme heard by the profession. Medicine is being driven by financial concerns—mostly caused by external forces—and not so much by the Head, the Heart, and the Hand, as expressed by Jim Priestley in 1954 in a Presidential Address. As a surgeon, I had hoped to dwell in this address on a scientific topic or a scientific advance, but unfortunately, the socioeconomic changes that are occurring today are the most pressing problems facing physicians and their patients. Yes, these changes may affect the pocketbook, but the real concern is that they will have an adverse effect on the quality of care and the people's access to it.

True to its purpose, the College has given birth to activities that have improved the quality of patient care—notably the Joint Commission on Accreditation of Hospitals, now the Joint Commission on Accreditation of Healthcare Organizations. Likewise, the College formed the Commission on Cancer, which has multidisciplinary participation; the Committee on Trauma, which sponsors a Trauma Center Verification Program; and the Committee on the Operating Room Environment; it sponsors the annual Clinical Congress (the largest surgical meeting in the world); and it developed the Surgical Education and Self-Assessment Program (SESAP), the *Patient Safety Manual*, and other educational programs and scholarships. An endowment program has just been established to help underwrite some of these pro-

grams. I do hope that the Fellows of the College will support this endowment effort, which is intended to take the pressure off of the dues structure and free up funds now required to address the socioeconomic issues with which we are faced. Contributions to the fund can be made along with the annual dues or at any time during the year.

Changing times

In earlier, simpler years, the physician/patient relationship was just that—the patient and the physician dealt with each other in a one-to-one relationship. The patient went to the physician of his choice, and the physician provided the care that was indicated based upon his or her experience and on the available knowledge. The physician was the patient's advocate, and compensation was usually agreed upon without controversy. The physician did his best, and the patient paid the fee if and when he could; there were no preconditions complicating the relationship.

After World War II, changes began to occur rapidly in the medical profession. There was an increase in specialization to the extent that today there are over 60 "types" of physicians. No longer is a single physician most often in charge of a patient. An explosion in technology has also occurred, increasing the physician's capabilities in diagnosis, treatment, and rehabilitation. However, these advances have further diluted the one patient/one physician relationship.

Unfortunately, some of our technical capabilities are overutilized. If the classic clinical knowledge was applied, less expense would be required. Yet, underutilization of new technology jeopardizes the quality of care that some patients require and that has led to improvements in longevity and quality of life. Non-use of technology also brings into question adequacy of practice, and often medicolegal factors come into play.

It is said that like food, clothing, and a roof over your head, health care is a "social good." Therefore, society as a whole through government, insurance companies, labor unions, and business and industry, has the right and the *responsibility* to be a participant in health care delivery. This philosophy, howev-

PHYSICIAN/PATIENT RELATIONSHIP

Dr. Beahrs, emeritus professor of surgery at the Mayo Clinic in Rochester, MN, is a former Chairman of the College's Board of Regents and is the newly installed President. He delivered this Presidential Address during Convocation ceremonies at the 1988 Clinical Congress.



er, unfortunately has been the basis of a push for socialized medicine, universal health care, or changes in the administration and financing of medicine. The responsibility is gradually being taken out of the hands of the physician and passed onto the "third party," which now controls the purse strings.

An explosion in demand

The United States government, for a long time and at various levels, has been responsible for the provision of health care for the indigent, veterans, railroad and marine workers, underprivileged people, and those patients who have certain chronic diseases. In 1965, a significant change occurred in this system with the advent of Medicare, which was intended to provide health care for the elderly—Part A, hospital care, and Part B, physician care. Medicaid was initiated as a joint program between the federal and state governments to cover care for those who had no insurance coverage or who were unable to pay for health care with their own resources. The social planners who designed these programs did not see the explosion in demand for health care services, increases in the number and types of health care services covered, and the technological advances (and their attendant costs) that can be used to maintain life. Now the physician has to determine what insurance plan the patient has, and if it will pay for the tests he or she thinks are needed. Can the patient be referred to the best-qualified physician if need be? Is a second opinion required, can the patient be admitted to the hospital, and must the physician plead with some faceless voice on the phone for an extra day or two in the hospital and have his services to a patient reviewed by a peer review organization? (Such review should be performed by his or her true peers and not by anyone less qualified).

Third-party programs have made funds available for health care services for beneficiary groups and have basically altered the traditional culture of the physician. The physician's altruism has gradually undergone change because of outside forces. With funds available from a third-party payer, the physician naturally and legally feels it is justified to collect

for all of his or her services. Unfortunately, when unrealistic rules and regulations restrict his freedom, it is only human to maneuver to get around them.

With an increase in the number of beneficiaries enrolled in health care programs, increases in the number of services covered, costly technology, and inflation, the total costs of these programs have soared. So, today the total cost to society for health care is \$500 billion. Federal outlay for Medicare is over \$80 billion. The Part B program for Medicare amounts to almost \$30 billion, 75 percent of which is paid directly to the physician. Overall, the physician may influence the spending of 70 percent of the Medicare dollar although he receives less than 25 percent.

While most physicians expect a reasonable return for their services, educational investment, and financial security, there are those few, a small number, who take advantage of the system and profit unduly from it. They do so by manipulating the coding system for charge purposes: unbundling of services, upcoding or code creep, increasing the volume of services, and so on. Unfortunately, there are numerous deficiencies in the Medicare program that allow some physicians to attempt to maximize their reimbursement. And, unfortunately, the use of these practices by some reflect adversely on the entire profession.

It should be noted that these problems are not always the fault of the physician, but can be attributed to the third party. The physician has wide variation in his or her practices, and the third party often fails to give appropriate instruction and uses a coding system that is excellent for record keeping, but inappropriate for charge purposes. The current litigious environment in which we work requires us to practice defensive medicine to a certain degree, which adds an unspecified but significant amount to the overall cost of medical care.

The amount of administrative responsibility that is off-loaded by the government and other third parties, restrictive regulations, and nonclinical requirements for practice add costly overhead to the physician's practice of medicine, which is not compensated for by the third party and which distracts the physician from his or her primary purpose. In some

PRESIDENTIAL ADDRESS

instances, it has led to difficulty in maintaining the professionalism of the profession in the face of increasing bureaucracy. Using the terminology of the business world, such as the word "provider," is not appropriate when used in reference to a profession.

Is the physician really the cause?

Since the physician is responsible for more than 70 percent of health care costs—although he receives less than 25 percent of it—the third party looks at the physician as being the cause of the high cost of this country's health care, which is now about 11 percent of the Gross National Product. But if the public wants the best medical care, demands high-quality care, and is unwilling to ration care, then 11 percent will probably not be sufficient funding to provide the highest level of health care in the world to our society. Life expectancy has increased by four years in the past decade, not because of better genes, but because of measurable improvements in health care made available to people by experts who provide specialized, cost-effective care.

The national debt is large, the federal budget is completely out of balance, and Congress appears unwilling or unable to do anything about it. As a result, the "budget balancers" are looking at the big ticket items, and health care is a major one. Cutting back on health care to save money is like carrying fewer lifeboats on an ocean liner to save money—when you really need one, no cost is too great.

Determining that physicians are a major part of the problem, Congress in 1985 established the Physician Payment Review Commission (PPRC) as its advisory body with regard to making changes in physician reimbursement. PPRC is a politically appointed body that has 13 members: five economists or sociologists, one nurse administrator, one business executive, and six physicians, only three of whom are in clinical practice, and one who is a university surgeon. There is no representation from the private practice of surgery or from the surgical specialties.

Arbitrarily deciding that a charge-based fee schedule was badly flawed, the Commission decided that a resource-based fee schedule would be the way to go.

In my opinion, most nonphysician members of the PPRC consider the practice of medicine and providing care to sick patients to be very simplistic; they do not appreciate the intricacies and complexities of the practice of medicine that take a physician 10 or more years to learn. Never have I seen a representative of a third party at a hospital at 2 a.m., at a Saturday grand rounds, or caring for a critically ill patient on a Sunday afternoon. In addition, members of the PPRC have their own biases and their own pet territories to protect—Medicare beneficiaries, members of their own specialties, and the disadvantaged and underprivileged. Yet much of the discussion at PPRC meetings centers on surgical costs, with minimal representation from the surgical community.

Although PPRC has not as yet endorsed the project that was done by the Harvard University School of Public Health, with subcontract support from the American Medical Association, it is looking at it very carefully and undoubtedly will use it as a basis for any resource-based relative value scale (RBRVS) that it might recommend to Congress. As you may know, the American College of Surgeons did not participate in the Harvard project because it had some conceptual and technical reservations concerning the project.

For one thing, the College has not endorsed the campaign of several nonsurgical specialty groups for enhancement of payment for so-called cognitive versus procedural services. For another, the Harvard project to develop an RBRVS is outside the control of organized medicine, and the study does not involve all medical and surgical specialties. In addition, the principal investigator, a health care economist, projects a high error rate (as high as 25 percent) attached to his methodology. And, too great an emphasis has been placed on the time required to provide a service or services. The philosophy that if it takes longer it must be better does not hold. Finally, no consideration is given to the experience of the physician or the quality of the care rendered. The bias is best illustrated by a quote made by the principal investigator: "Charges for treating fearful diseases and life-threatening or emergency conditions may be less a reflection of what a patient is willing to pay than an exploitation of his or her fears

PHYSICIAN/PATIENT RELATIONSHIP

and anxieties" by the physician. If this is true, the scientific results can hardly be considered scientific.

Although the purpose behind establishing the PPRC was that its recommendations would have a favorable effect on the budget and deficit, we have to ask the question, are Congress and the federal bureaucracy sufficiently disciplined to accomplish this goal? Not by example. Rarely have regulations reduced costs. It seems that the PPRC's main thrust may be to accomplish a redistribution of financial resources among physicians, justified or not. In other words, they will be addressing the so-called cognitive versus procedural issue, which is basically a non-issue in budget reduction. In actual medical practice, there is no greater period of cognition than when an operation is being performed.

Members of the PPRC express concern regarding quality of and access to care, but the changes being considered and the lack of appropriate support for the health programs indicate that many of them are just paying lip service to both. If high-quality health care is to be available to all of our citizens, additional financial resources will be required (even though inefficiencies and excesses in the present system are controlled). Where regulations and certificate-of-need requirements are most stringent, it appears that in some cases the quality of care is poorer, in that mortality and morbidity are higher. And where mandatory assignment has been legislated—primarily in Massachusetts—an unfavorable trend in losing available medical personnel for the future is already becoming obvious. Other states that have legislated more flexible mandatory assignment programs (Connecticut, Rhode Island, and Vermont) may also face problems in the future. Although beneficiaries pay equal insurance premiums, financial benefits vary widely, hardly reflecting a sound annuity program. Medicare was not instituted as a welfare program, as it subsequently has evolved.

An adverse effect

The turmoil that is occurring in the socioeconomic environment stimulated and initiated by the third parties in medicine; the difficulties of practice due to

rules, regulations, and restrictions; the medicolegal professional liability situation—all will have long-term unfavorable effects on the practice of medicine in the United States. The Graduate Medical Education National Advisory Committee (GMENAC) study projected a surplus of physicians in the 1990s; it was thought that competition would then become a major factor in cost control. This surplus most likely will not occur.

In the last few years, the number of medical school positions has decreased, and the number of qualified applicants is down from a high of 3.5 per position to 1.7 today. The change in percentage of men and women in medicine is reducing the full-time equivalents (FTE) in practice (male 1, versus female .7 FTE). The overall grade point average of those admitted to medical school has decreased. Some medical schools no longer have required premedical subjects.

Professional liability has become such a problem that physicians are retiring early (the legal community seems to have as its purpose not to spread justice but to spread wealth); restricting their practices; moving into sheltered practices, academia, or out of medicine into a related or unrelated business; and becoming progressively discouraged about a physician's ability to control his or her destiny.

All of these factors adversely affect the number of physicians. Of great concern is the lack of interest in research and technology development. These things do not speak well for the maintenance and advancement of the best health care system that exists in any country in the world. Why should a bright young man or woman go into a profession in a society that has such a poor image of the profession and that is restricting the freedoms of its members? There are indications that these young people are looking elsewhere for fulfillment. The culture of the physician 10 years from now could be entirely different than it has been in the recent past.

The third parties can regulate the administrative structure and financing of health care, but the one thing they cannot control is quality. Only the physician and surgeon can provide high-quality care, and only if he or she is free to do so by practicing the art and science that he has acquired through years of

PRESIDENTIAL ADDRESS

training and experience. Likewise, health care professionals are particularly responsive to peer-derived data to be used in providing and improving the quality of health care. Society wants the best, and the profession must capitalize on its capability to provide high-quality care and once again gain control of its destiny.

What can be done?

The recitation of some of the socioeconomic changes and their adverse effects sounds like the doom and gloom of medicine, but that is not necessarily so. The members of the medical profession should stand together and communicate with each other, their patients, and with the public as never before. Let them know that the doctor stands ready to serve as advocate for the patient unlike the third party, which really is a wolf in sheep's clothing—pretending to represent the patient, but running a business and attempting to make money any way it can. The physician is not financially driven but does require sufficient reimbursement in order to be able to provide the care the patient wants. Because we have limited public resources, society may have to make some choices and establish priorities with regard to the availability of health care. The patient must know what the warranty is in health care programs established by third parties. Ethically, these choices cannot be made by the physician.

"Communications" is a key word today, and improved communications are urgently needed. Efforts along these lines are being undertaken in a variety of ways, and such endeavors must be expanded. In Ramsey County, MN, for example, physicians are sponsoring a "Mini Internship" for selected persons: union and business representatives, lawyers, members of the media, and members of senior citizen groups. The internship lasts for two days, beginning with an orientation dinner. Each "intern" then spends four half-days following four physicians through their daily work schedule. The program ends with a concluding meeting, during which comments uniformly reflect a better understanding of what physicians do and what they face. Finances do seem to be viewed as being of secondary importance. Other comments have been made regarding the high

level of technology physicians deal with and the tough decisions that must be made, often in a short period of time. Programs such as this one should be widely emulated. This is an example of only one communications mechanism. There are others. Public membership or participation on the boards and councils of medical societies is a must. Developing such relationships takes time, but the rewards could be enormous.

Within the confines of the law, the profession should more stringently police itself and identify those physicians who are not practicing the best medicine or who are acting unethically. Peer review should occur across "party" lines—university physicians, private physicians, and uniformed service physicians. Those who charge unreasonable fees or who provide poor quality care should be reported to appropriate groups for disciplinary action. Legislation to permit such activities must be supported and must provide protection to those who participate in peer review.

Fees should be commensurate with patient's ability to pay. This arrangement is part of the culture of the physician. Legislating mandatory assignment is contrary to the freedoms of this country. Most physicians practice with altruism and with honesty—the well-being of the patient in all respects is his or her primary concern.

Regardless of the changes that are occurring in the socioeconomic environment, the practice of medicine will always be a satisfying profession based on the challenge of dealing with health care problems on a one-to-one basis with the patient. As in years past, we should encourage bright young men and women to go into medicine and medical research and teaching. We will be able to maintain the highest quality of care for our people and advance science for the benefit of mankind only if the physician of the future is well qualified and motivated.

Physicians have invested many years and a large amount of resources in training, and they are due a reasonable return on that investment. Physicians certainly should not profit unduly from the misfortunes of patients and certainly should not flaunt an excessive lifestyle.

In this day of specialization and subspecialization, medicine, in many respects, has been badly fractionated. This trend must not lead to the "fractionation"

PHYSICIAN/PATIENT RELATIONSHIP

of the patient. One physician must be in charge, and each doctor who sees the patient must practice the art of medicine and communicate with the patient. Do not let the cognitive/procedural issue divide us. Each of us had made a decision as to specialty and has established his or her own work habits.

During the past several decades, medical technology has advanced rapidly and has given us many more tools to work with. However, this capability should not be overutilized. Review medical history, read the classics of medicine, and practice its art; with the use of this knowledge, expensive technology is not always necessary.

Controlling our own destiny

If through improved communications we can once again gain the understanding and the respect of the public and retain our freedom, we will once more be able to control our destiny without the interference of third parties in medical decision-making and will be able to offer all patients the best that we can. The third-party payers will continue to be active in the spheres of administration and financing, and we cannot reverse or prevent their involvement. We must work with business, the insurance industry, and the government in these areas and jealously guard the physician's right to medical decision-making.

As physicians and surgeons, you have dedicated your lives to the art of medicine and to the benefit of your fellow man. Although there are other rewards of the profession such as material gain and position in society, nothing surpasses the satisfaction of helping the patient if help is humanly possible.

The encounter between the physician and the patient cannot affect the soma and soul of the one without also affecting that of the other.

All physicians are affected similarly, but the surgeon is exposed to the ups and downs of medical practice more acutely because of his or her active and aggressive intervention in the illness of the patient. You do far more than participate in establishing the clinical diagnosis; others can give opinions, but you alone have to make the final decision for operation. Your years of surgical training and acquired technical ability are forged into the performance of an operation to treat the pathology encountered, most often with success, but sometimes without. The well-being of the patient weighs heavily on your mind

as you leave the operating room. Many thoughts undoubtedly race through your head: Was the operation appropriate, did it help, was it well done, will it offer the patient a chance of cure and life, does the patient need additional treatment, what to tell the patient and the relatives, and what decisions need to be made to ensure the patient's return to good health during the postoperative period.

Because of the mental processes and physical exertion involved in an operation, you may be physically and emotionally drained, which can be reflected in both your appearance and mood, but a bond has been created between you and your patient—and it is one in which there is no place for the third party.

Resources are expended in the treatment of the patient. In years gone by, this was an issue to be resolved between physician and patient and it was handled well by charging a reasonable fee, which was almost always commensurate with the patient's ability to pay, whether in money, chicken and eggs, or nothing at all.

Today the third party has entered the picture and in part has accepted financial responsibility for medical care. In turn, the physician has required financial accountability, but in the process is losing his clinical freedom, to the detriment of the patient with regard to access and quality of care. We must reverse and prevent this trend. There is a place for each of us in this triangle. Let us work toward strengthening our relationships and not interfering with others.

As physicians, let us rededicate ourselves to the fundamentals of our profession—clinical care, academic achievement, and teaching—and let us strengthen our moral sensitivity and humanism in practice.

Let us foster the best changes in the health care environment, altering the way in which the public views its physicians, and gaining the respect and confidence of our patients by once again being their advocates.

We should work with the third party in the administration and financing of health care, but without its interference in the medical decision-making processes that are the main components of high-quality patient care. Never again will the medical profession return to the autonomy that once marked its relationship with society. The financial bottom line certainly should not be the measure of success for the physician. The satisfaction of having done your best for the patient should be.