Special Communication

The Physician's Role In Health Care Reform

Margaret A. Kirkegaard, MD

Abstract: **Health care in the United States is in crisis. The desire to provide care continually conflicts with the need to contain costs. Historically, physicians have opposed the demand for health care reform, and although many physicians have responded to the current crisis with ambivalence, apathy, or frustration, they have the knowledge, capability, and opportunity to advocate for and to effect reform within the health care delivery system. Many believe that the acknowledgment of costs as a factor in treatment decisions compromises their role as patient advocates, but in the face of increasing government controls and the corporatism of medicine, the human link between physician and patient is even more valuable. The current crisis in health care necessitates cost control. If physicians conscientiously undertake their political, professional, and personal roles, they can reform the health care delivery system in the United States while compassionately advocating for their patients. (J Am Board Fam Pract 1993; 6:163-167.)**

During the past election year, health care became a highly charged political issue. Although this issue is complex, the debate often has focused on a central problem — that the desire to provide care for patients continually conflicts with the need to contain health care costs. Concern is growing about the number of persons in the US who lack access to adequate health care. Statistics on these persons are significant: 37 million are uninsured,[1] another 20 million have difficulty securing care because of financial barriers,[2] and the proportion of poor families covered by Medicaid has dropped from two-thirds to one-half.[1] At the same time, the rampant inflation of health care costs has generated similar attention. These costs represented 5 percent of the gross national product in 1940, rose to 11 percent in 1989, and are projected to reach 15 percent by the turn of the century.[3] Patients plead for care as economists demand cuts.

Recently many potential solutions to this dilemma have been promulgated, most of which fall into four categories: (1) universal, government-sponsored insurance; (2) a system of tax credits and savings incentives for individuals to purchase their own insurance; (3) a compulsory employer-provided health insurance, with government insuring the unemployed; and (4) a system that requires employers to provide health insurance to employees or pay a tax, with government insuring the unemployed.[4] Although the political and ethical philosophies underlying these proposals vary, they all are alike in that legislation would be required to implement them. In the past Congress has been hesitant to legislate changes within the health care industry, and certainly the current political climate already has shown that legislative proposals concerning health care evoke fierce political debate. This reliance on Congress to solve the current health care crisis ignores the nascent potential of physicians to enact reforms.

Physicians as a group do not agree on many political and professional objectives. Consider the response of physicians to the newly adopted resource-based relative value scale (RBRVS). The cognitive and primary care specialties lobbied actively for the enactment of the RBRVS, whereas the surgical specialties criticized the RBRVS as "flawed."[5] Physicians can on an individual level, however, promote reforms within the health care industry that will help to control costs without compromising care. As ethicist Edmund Pellegrino[6] writes,

> No matter what happens in politics, legislation, or social transformation, we must never forget that we are "the final common pathway" for everything that happens to the patient. No policy or regulation can be applied to our patient without going through us. We are the patient's final safeguard.

Submitted, revised, 25 September 1992.

From the Hinsdale Family Practice Residency, 135 N. Oak Street, Hinsdale, Illinois. Address reprint requests to Margaret A. Kirkegaard, MD, 135 N. Oak Street, Hinsdale, IL 60521.

Physicians have the potential to assume greater responsibility in shaping the health care delivery system in the United States.

On a personal level most physicians have responded to the health care crisis with apathy, ambivalence, and frustration. A physician's enemies used to be pestilence, disease, and death. Images of Ehrlich with his "magic bullet"[7] or Arrowsmith waging war against the epidemic[8] inspired many would-be physicians. Today physicians parry new enemies — hospital administrators, utilization review committees, insurance companies, and government bureaucracy — paper tigers with real teeth. In a survey of North Carolina physicians, 79 percent of the respondents thought that physician control over patient treatment had declined in the past 5 years.[9] Pellegrino summarizes well the attitudes of physicians: "All are afflicted with moral lassitude, with the conviction that we are victims of a conspiracy of ambulance-chasing lawyers, opportunistic politicians, callous economists, bottom-line administrators and disaffected patients."[6] Instead of challenging the system, many physicians have acquiesced and often feel compelled to resort to bureaucratic subterfuge to provide needed care to patients while obtaining reimbursement from insurance companies.

Physicians have the knowledge, capability, and opportunity to advocate for and to effect reform within the health care delivery system. Until the rapid proliferation of cost-containment controls during the last decade, physicians were the most powerful determinants in the health care delivery system.[10] Even now physicians exert tremendous influence on the amount and type of health care services that are purchased. Although only 20 percent of health care costs are paid to physicians, an estimated 70 percent of those costs are determined by physicians.[11]

There are several goals that physicians can accomplish to help control health care costs without limiting patients' access to care: develop uniform treatment policies, clinically substantiate treatment efficacy, support primary care, learn cost-containment strategies, participate in health care management, practice "defensively" by improving physician-patient communication, and, most importantly, make cost-conscious decisions in clinical practice.

First, physicians need to develop more uniform treatment policies. In one study more than 75 million claims for Medicare services were analyzed. Of 123 procedures studied, 67 had at least a threefold utilization difference between the sites with the highest and the lowest rates of use. Individual geographic locations did not consistently exhibit the highest or lowest rates for all the procedures studied.[12] Because of the statistically large number of patients enrolled and procedures performed, it is impossible that these variations were secondary to patients' conditions. Society likes to regard medicine as a science, but in actuality much of patient care is determined by professional tradition and personal experience. Physicians tend to prescribe in the shadow of their latest complication. Physicians need to evaluate treatments and procedures critically and delineate more specific cost-to-marginal-benefit ratios. How many of the commonplace treatment policies, such as admission chest radiographs and presurgical laboratory tests, could be eliminated if the cost-to-marginal-benefit ratio were clearly defined?[13] One study showed that 47 percent of laboratory tests could be cut without any measurable decrease in the quality of care.[14] Correcting for the variation, waste, and indiscrimination in everyday clinical practice policies represents important potential savings that are immediately available, under the exclusive control of physicians, and require no legislation.

The development of uniform treatment policies with explicit cost-benefit ratios necessitates the second goal — physicians need to research and clinically substantiate the efficacy of treatment policies. Caplan[15] noted that the Institute of Medicine of the National Academy of Sciences and the Congressional Office of Technology Assessment have both issued reports stating that less than 10 percent of medical interventions have been subjected to any form of clinical trial. The amount of money allocated by the federal government and third-party insurance companies toward research represents only 1 percent of their total expenditures.[16] Unfortunately, current short-sighted attempts at cost control tend to sacrifice research budgets first, which ultimately prevents the development of rational cost-conscious policies. Research, traditionally performed in tertiary care centers with an abnormally sick population, must shift to the primary care setting. Networks of primary care physicians need to be established to pool data from several sites and

distill collective experience into statistically valid conclusions. Medical education should include training in research design, statistics, and analysis so physicians are equipped to challenge traditional protocols critically and objectively.

Third, physicians need to support primary care. In the United States only 8 percent of physicians are family physicians, whereas in England 60 percent of all physicians are general practitioners.[17] Currently an increasing amount of general care is provided by nonprimary care specialists.[18] Primary care physicians can care for patients more cost effectively. Consider the example of a 50-year-old woman with hypertension who sees a cardiologist for the management of her hypertension and a gynecologist for her yearly female examination. A primary care physician could manage both aspects of her medical care. Because of the physician's comprehensive knowledge of the patient, duplication of tests and procedures would be avoided.

Udall,[11] summarizing the findings of four independent studies comparing family physicians with internists, noted that overall family physicians had lower hospital utilization rates and fewer referrals to consultants. More recent data also have supported the conclusion that family physicians have a lower utilization rate of medical resources.[19] The holistic nature of family practice, with its emphasis on comprehensiveness and continuity, is essentially more cost effective.

Barriers such as lower salaries, decreased prestige, and curtailed hospital privileges would have to be eliminated to attract more medical students and residents into family practice. Historical antagonism between primary care physicians and specialists needs to be eliminated. The medical education process almost exclusively emphasizes technical competence and factual knowledge. There must be an opportunity for young physicians to explore the culture of the medical profession and to become animated by the political, social, and moral potential of the healing art, so that specialists and generalists can share a common dialogue.

Fourth, physicians need to learn cost-containment policies. Greene, et al.[20] showed that 92 percent of physicians surveyed had no formal training in cost-containment strategies. Nearly one-half of the respondents agreed that such training would be valuable and should be required for all physicians, particularly for medical students and residents. McPhee, et al.[21] also found enthusiastic acceptance of a cost-containment curriculum in postgraduate medical education. Several studies have shown that patterns of medical decision making can be altered successfully to consider costs.[14] Cost-benefit ratios cannot be considered in medical decision making unless the costs and less expensive treatment options are thoroughly known.

Fifth, physicians need to participate in health care management. Token representation is not sufficient. The subterfuge that physicians often adopt when dealing with administration, utilization review committees, and insurance carriers must be eliminated. Autonomy has always been highly valued by many physicians. But while autonomy in clinical practice must be defended, professional autonomy must be replaced by cooperation and participation. Physicians often perceive themselves as too busy to become involved in policy-formulating coalitions, but the current crisis in health care necessitates such leadership.

Sixth, physicians need to address their concerns about malpractice litigation more effectively. This threat exacerbates both sides of the health care conflict: it inflates costs and decreases access to care. Reynolds, et al.[22] estimated that from 1983 to 1984 the average malpractice insurance premium rose by nearly 20 percent, or $1300. In addition to the actual premiums, physicians surveyed by the American Medical Association reported making practice changes totaling $4600 per physician per year to counter the threat of litigation. Other studies have shown that physicians are eliminating specific services or refusing to treat patients perceived as high risks for litigation.[23] Some relief for this situation needs to come from the courts — limits on awards for pain and suffering, decreased statutes of limitations, penalties for nuisance suits, and caps on legal fees — but physicians themselves could do more to rectify the situation. Physicians often are compelled to obtain technological confirmation of the lack of disease as the primary defense against the threat of suit. Nevertheless, perhaps as much as one-third of all claims are generated by poor physician-patient communication or failure to provide and document informed consent.[24]

Most importantly, physicians need to advocate compassionately for patients while considering

objectively the cost-to-marginal-benefit ratio. Perhaps because technology has outstripped confidence, modern medicine is characterized by the tendency to substitute tests and procedures for medical judgment and clinical acumen. The state of the art has become the standard of care. Physicians must reevaluate their own motivations and determine whether ordering tests and procedures is treating themselves or their patients. Gabbard[25] describes the "triad of compulsiveness — doubt, guilt feelings, and an exaggerated sense of responsibility" that characterizes the physician's psychological makeup. Eighty percent of all physicians satisfy three of the five criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (third edition)[26] for "compulsive personality."[25] This compulsiveness, while it creates competent physicians, escalates costs. Much of medicine, particularly intensive care with critically ill patients, is permeated with the "it might help and probably won't hurt" mentality. The goal is not to do everything technologically possible for a patient, but to prescribe treatments and pursue diagnostic workups that have reasonable probabilities of benefiting the patient. The existence of a technology does not justify its use. High-quality care does not have to be expensive. The benefits of fewer tests and procedures extend beyond decreased costs and include less patient discomfort, anxiety, and complications. Referrals to subspecialists are often made to dilute the anxiety and self-doubt of caring for a deteriorating patient. The psychological need to consider every diagnostic possibility, no matter how remote, becomes justification for consultation. Physicians must have confidence in their judgment and courage in their care.

Many have objected to the involvement of physicians in cost containment, arguing that financial limitations will define the standard of care.[27] But in reality, a patient's ability to pay has always been a powerful, though covert, factor in medical decision making. A recent study of nearly 38,000 patients reported that privately insured patients had an 80 percent greater chance of receiving angiography than uninsured patients, a 40 percent greater chance of receiving bypass grafting, and a 28 percent greater chance of receiving angioplasty.[28] Another study analyzing five high-physician-discretion diagnoses found that the uninsured patients' lengths of stay are significantly shorter than those of privately insured patients. In the same study, patients without insurance were shown to be 29 percent less likely to have coronary artery bypass graft surgery, 75 percent less likely to have total knee replacement surgery, and 45 percent less likely to have total hip replacement surgery.[29] The decision to perform knee surgery or angiography or discharge a patient is ultimately made by a physician, not an insurance company, peer-review committee, or legislator. Of course, the threat of being denied admission privileges if a physician is perceived as continually overutilizing hospital resources is very real. But if all physicians would use the same cost-conscious discretion for all patients, regardless of payment status, health care inflation might be curbed. Physicians might even regain some autonomy in their practice, because imposed rationing of certain services (as happened in Oregon) would be unnecessary.[30] It must be clear, however, that cost can never be the sole limiting factor in treatment decisions. If a costly procedure would clearly benefit a patient — for example, a heart transplant for a patient with terminal congestive heart failure — then undeniably treatment should not be withheld in the rationalization that the money would be better spent elsewhere. Every case must be individually examined, with costs considered as one of the multiple factors in arriving at a decision. This reason is precisely why physicians, not insurance companies, need to make cost-conscious decisions.

Individuals are healed by physicians, not by governments, agencies, or insurance companies. In the context of increasing government controls and corporatism of medicine, the human link between physician and patient is even more valuable. As one patient writes, "My pain, my weakness, my illness — unlike my thoughts on these matters — are absolutely unsharable. Even the socialization of medicine could not socialize the radically private property of the body."[31] When the physician bends to listen to the patient's heart, the soft lub-dub is an affirmation of the covenant between these two human beings. It must not be obscured by the noisy wheels of bureaucratic medicine, but the current crisis in health care necessitates that physicians are also attentive to their role in cost containment. If physicians conscientiously strive to accomplish these goals in daily practice, they can curb health care inflation without jeopard-

izing patient care or compromising their roles as patient advocates.

References

1. Woolhandler S, Himmelstein D. Resolving the cost/access conflict: the case for a national health program. J Gen Intern Med 1989; 4:54-60.
2. Kitzhaber J. Access to health care a US concern. Am Fam Physician 1989; 40(5 Suppl):19S, 22S.
3. Eddy DM. Clinical decision making: from theory to practice. What do we care about costs? JAMA 1990; 264:1161, 1165, 1169-70.
4. Blendon RJ, Edwards JN. Caring for the uninsured. Choices for reform. JAMA 1991; 265:2563-5.
5. Glaser WA. Designing fee schedules by formulae, politics, and negotiations. Am J Public Health 1990; 80:804-9.
6. Pellegrino E. The dark wood: medicine's moral malady. University of Minnesota Med Bull 1989; Summer:2-5.
7. Gillispie CC, editor. Dictionary of scientific biography. New York: Charles Scribner's Sons, 1971.
8. Lewis S. Arrowsmith. New York: P.F. Collier and Son, 1925.
9. Bulletin of North Carolina Medical Society, August 1990.
10. Jonas S, editor. Health care delivery in the United States. 3rd ed. New York: Springer, 1986:506.
11. Udall KS. Cost efficiency: a new dimension of emphasis for family practice. J Fam Pract 1984; 19:601-3.
12. Chassin MR, Brook RH, Park RE, Keesey J, Fink A, Kosecoff J, et al. Variations in the use of medical and surgical services by the Medicare population. N Engl J Med 1986; 314:285-90.
13. Angell M. Cost containment and the physician. JAMA 1985; 254:1203-7.
14. Martin AR, Wolf MA, Thibodeau LA, Dzau V, Braunwald E. A trial of two strategies to modify the test-ordering behavior of medical residents. N Engl J Med 1980; 303:1330-6.
15. Caplan AL. Hard data of efficacy: the prerequisite to hard choices in health care. Mt Sinai J Med 1989; 56:185-90.
16. Relman AS. Assessment of medical practices: a simple proposal. N Engl J Med 1980; 303:153-4.
17. Benjamin WW. Will centrifugal forces destroy the medical profession? N Engl J Med 1989; 321: 1191-2.
18. Fahs MC. Ethics and economics: implications for primary care training. Mt Sinai J Med 1989; 56:194-5.
19. Greenfield S, Nelson EC, Zubkoff M, Manning W, Rogers W, Kravitz RL. Variations in resource utilization among medical specialties and systems of care. Results from the medical outcomes study. JAMA 1992; 267:1624-30.
20. Greene HL, Goldberg RJ, Beattie H, Russo AR, Ellison RC, Dalen JE. Physician attitudes toward cost containment. The missing piece of the puzzle. Arch Intern Med 1989; 149:1966-8.
21. McPhee SJ, Chapman SA, Myers LP, Schroeder SA, Leong JK. Lessons for teaching cost containment. J Med Educ 1984; 59:722-9.
22. Reynolds RA, Rizzo JA, Gonzalez ML. The cost of medical professional liability. JAMA 1987; 257: 2776-81.
23. Weisman CS, Morlock LL, Teitelbaum MA, Klassen AC, Celentano DD. Practice changes in response to the malpractice litigation climate. Results of a Maryland physician survey. Med Care 1989; 27:16-24.
24. Harris JE. Defensive medicine: it costs, but does it work? JAMA 1987; 257:2801-2.
25. Gabbard GO. The role of compulsiveness in the normal physician. JAMA 1985; 254:2926-9.
26. Diagnostic and statistical manual of mental disorders. 3rd ed. Washington, DC: American Psychiatric Association, 1978.
27. Levinsky NG. The doctor's master. N Engl J Med 1984; 311:1573-5.
28. Wenneker MB, Weissman JS, Epstein AM. The association of payer with utilization of cardiac procedures in Massachusetts. JAMA 1990; 264:1255-60.
29. Hadley J, Steinberg EP, Feder J. Comparison of uninsured and privately insured hospital patients. Condition on admission, resource use, and outcome. JAMA 1991; 265:374-9.
30. Daniels N. Is the Oregon rationing plan fair? JAMA 1991; 265:2232-5.
31. Friedman E, editor. Making choices: ethics issues for health care professionals. New York: American Hospital Publishing, 1986:127.