

Physicians and Society:
Renegotiating
the Contract

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The 1987

Michael M. Davis Lecture

CENTER FOR HEALTH
ADMINISTRATION STUDIES
GRADUATE SCHOOL OF BUSINESS
DIVISION OF BIOLOGICAL SCIENCES
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THE SPEAKER

Mr. Iglehart is the founding editor and creator of *Health Affairs*, an award-winning policy journal published by Project HOPE. In five years of publishing, the journal has become a nationally respected forum for the expression of disparate views on policy issues. During this period, it also has become the largest of the health policy journals with which it competes. In addition, Mr. Iglehart is a national correspondent for *The New England Journal of Medicine* and author of the monthly essay, "Health Policy Report", published in this medical journal. "Health Policy Report" ranges across a broad variety of issues, including the examination of foreign health systems.

THE OCCASION

Mr. Iglehart delivered this lecture at The Ambassador West, Chicago, on May 8, 1987.

INTRODUCTION

America's relationship with its physicians, never a simple equation to describe or define, is changing. While physicians will remain a self-regulated profession, the public is demanding through a variety of mechanisms that it be granted greater access to the doctor's world (and the hospital's as well, I might add) and how they function. Whether, in the end, these developments will improve the quality of care and the physician's relationship with his or her patient is open. But one thing seems quite clear. The doctor's world is changing, and many of the changes revolve around the social responsibilities of the profession.

The importance of public opinion regarding the behavior of the medical profession cannot be underestimated. Indeed, the gauging of public opinion has become an almost consuming pastime in many walks of American life. Whether in politics, industry, medicine or other enterprises, leaders seek an understanding of changing public opinion on pressing issues of the day. In this regard, the medical profession is no different.

For a decade now, the American Medical Association (AMA) has conducted periodic nationwide surveys of public attitudes on health care issues. At the same time, the AMA has kept track of the changing attitudes of physicians. I do not plan to discuss in any detail the results of these surveys, but I will point to one interesting finding in the association's 1986 results.

Every year, citizens who participate in the AMA survey are asked early in the interview: "What do you feel is the main problem facing health care and medicine in the United States today?" A vast majority of the public consistently views cost as the main problem facing health care and medicine. A similar question was put to the random sample of physicians who participated in the survey last year. These answers represented a dramatic break with opinions of the past. Last year, for the first time, professional liability was defined by a plurality of physicians as the biggest problem currently confronting American medicine. When the association's pollsters asked physicians in years past to identify the main problem, "professional liability" as a response was so rare that it was not even coded separately; instead, it was buried in the category "other" and cost commanded the majority's attention.

I underscore this finding because I believe it points to the diverging view that the public has of physicians and that physicians have of themselves. While there are many explanations attached to the difficulties that physicians are having with medical malpractice, one that cannot be dismissed without additional examination is that many patients employ lawsuits against their doctors as a surrogate for dissatisfaction with their medical care. This vexing phenomenon is only one reflection of a larger reality and that is that Americans expect a great deal—and perhaps too much in many instances—of their physicians. It is after all, still very much a science *and* an art. Nevertheless, the fact that physicians are never far from the public's mind underscores the importance it attaches to medical doctors and the services they deliver. Indeed, there is no more valued service in America today than medical care. One solid indication of this high standing enjoyed by physicians and the care they render is that in one public opinion poll after another, Americans express themselves in support of increased taxation to finance more and better care, particularly among elderly people.

When I think of the changing relationship of the public to the medical profession, four developments come to mind that I will discuss. At the outset, I should make clear that while I emphasize these four developments, there are many others as well that reflect my intense belief that Americans are searching for a new paradigm in their relationship with doctors. Reaching that point will doubtless be a painful and long struggle, marked by valleys and peaks that are the hallmark of a dynamic, unplanned society. While change will not come easy—does it ever?—there is little to suggest that Americans really want to see in their physicians the attitudes and behavior patterns that more nearly reflect those of a businessman rather than those of a caring practitioner.

I will summarize the four developments and then discuss them at greater length. The first item is a new law that underscores the public's willingness to help medicine with its legal problems, but only at a social price. The second item revolves around another new law, a Massachusetts state statute that, even though under legal challenge, is influencing federal and other states' policies. The Massachusetts law reflects the public's concern over the cost of care and government's willingness to accommodate it through controversial

policies. The third development is an evolving change in the physician's role from one of total patient advocate without serious concern for medical economics to a prudent resource allocator living on a fixed budget. The fourth item revolves around the government's, and through it, the public's interest in having at its disposal more comprehensive information about the performances of physicians and hospitals.

REMOVAL OF INCOMPETENT PHYSICIANS

I will discuss these points in turn. The first item is a new law that strongly suggests that the public wants the profession to take a more aggressive stance regarding the removal of incompetent physicians from medicine. In this regard, the public and professional interests are coming closer together because of the growing number of practitioners and because of a greater recognition that care providers can and do occasionally harm people. One example of the profession's tougher attitude toward the errant practitioner came in the 1986 inaugural speech of the AMA president, who said the profession must remove its "sore spots: the incompetent, the arrogant, the fraudulent, the impaired, the greedy. We must rid them from the profession or rehabilitate them," Dr. John Coury said.

Beyond the obvious professional obligation to remove incompetent doctors from patient care, there is a practical political reason as well. Representative Henry Waxman, (D-CA), articulated it recently in *The New England Journal of Medicine* (April 9, 1987). Waxman, who despite his liberal instincts, has become one of the medical profession's better friends on Capitol Hill, wrote: "Before the medical profession can expect greater protection from malpractice suits, it has to convince the public that it is doing everything reasonable to police itself. Incompetent physicians must be identified and then must either improve their performance or be removed from practice. Simply allowing an incompetent physician to move quietly to another hospital or another state is not good enough to warrant the public's trust."

The public is not only demanding—through their elected representatives if no place else—that incompetent physicians be removed from practice. But Congress is also carving out a public role as well. A solid reflection

THE CONCERN OVER THE COST OF MEDICAL CARE

of this interest in public participation in the professional affairs of medicine can be found in a new law entitled the Health Care Quality Improvement Act of 1986. The law offers hospitals and physicians that engage in peer review broader legal protection against the threat of being sued by doctors who are disciplined as a result of the review process. At the same time, however, and this is the provision that reflects congressional interest in strengthening the public's capacity to scrutinize the medical profession, the law also requires professional societies, health care organizations and insurance companies to report to a national data bank all disciplinary actions taken against physicians and all settlements and verdicts in medical malpractice cases.

The AMA, which supported the new legal protections for peer review, strongly opposed the creation of a publicly-sponsored national clearinghouse for data on physicians in testimony, in lobbying and in meetings with elected officials. The AMA favored establishing the clearinghouse within the private sector and had initiated steps toward creating such an organization before the peer-review protection bill was introduced. In contrast, three other medical organizations—the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists and the American College of Physicians—supported both major provisions of the law.

Another solid indication that policymakers tie the likelihood of any legislative relief from questionable malpractice actions to the profession's willingness to police itself more aggressively came in the remarks of Representative Ron Wyden, who introduced the peer review protection bill March 12, 1986. Wyden, surrounded by representatives of the American Association of Retired Persons, the American Hospital Association, and the AMA, which he said were "jointly backing the legislation . . . after months of negotiations between my office and these groups," emphasized the importance of the bill in relation to the issue of medical malpractice. "There is no quick fix for the malpractice problem. But a good place to start is with the medical profession itself. Doctors are in the best position to do something about malpractice—because they see it happening around them. Most doctors are honest, hard-working, competent professionals. What's needed are new systems that encourage doctors to bring cases of incompetence to disciplinary authorities."

My second item relates to the public's continuing concern over the cost of medical care. As an aside I would note that while the concern is certainly genuine it seems to bear little relationship to another priority that the public attaches to medical care, and that is the pursuit of ever new treatments and technologies, regardless of their economic implications. Nevertheless, a new Massachusetts law points to the willingness of legislators there to tie new economic restrictions to medical licensure.

The law, supported by the administration of Governor Michael Dukakis, bars physicians, as a condition of licensure, from charging elderly and disabled Medicare patients more than the fees set by the federal program. The two-year-old law was recently upheld unanimously by a three-judge federal appeals court. The Massachusetts Medical Society and the AMA are appealing the decision to the U.S. Supreme Court.

The importance of the decision is less in the likely impact it will have on the incomes of Massachusetts physicians—over 90 percent of payment claims were on an assigned basis anyway—than as a precedent that other states will follow. Similar legislation has been introduced in California, Washington, Florida, Illinois, Indiana, Iowa, New York, New Jersey, Rhode Island and Vermont, according to the National Health Care Campaign, a clearinghouse organization concerned with health policy. On the other hand, New Hampshire, Maryland, Arkansas and Montana have recently defeated proposals that would have required physicians to accept Medicare fees as payment in full.

Dr. Barbara Rockett, president of the Massachusetts Medical Society at the time of the decision of the U.S. Court of Appeals, emphasized in her reaction to the ruling that, "it's the principle that we have been very concerned with." In addition to the loss of authority to set rates, she told *The New York Times*, "to be threatened with a loss of licensure is just beyond reality—we feel it's outrageous. The standards for licensure, as everyone knows," she continued, "should be ethical moral standards, the ability to practice, the ability to pass an exam." In Massachusetts at least, the state is adding a new economic standard to its requirements for medical licensure.

Interestingly, the state was represented in the case by its attorney general, James Shannon, who formerly pressed a similar Medicare payment policy approach while a member of the U.S. House of Representatives and its powerful Ways and Means Committee. Shannon, incidentally, comes from a family of physicians. There is well-founded skepticism in the ranks of physicians and hospital administrators about the motivations of government today regarding health care. There is no question that government's agenda is essentially wanting more medical care for less money, but that is no reason to abandon efforts to work with the public sector on behalf of your common constituent—the patient. If nothing else, the new peer review protection law underscores the willingness of government to work out accommodations with the medical profession, particularly when the interests of patients are prominent in relation to the issue at hand.

THE CHANGES IN METHODS OF PAYMENT

The third development that is reshaping American medicine is a change in the method of payment, from unfettered fee-for-service to a variety of prepaid modes. This change is most apparent in health maintenance organizations (HMOs), which voluntarily enroll individuals and provide them a comprehensive range of services for a fixed, monthly premium. These organizations are providing services under a set of philosophic tenets that parallels in a number of respects some of America's deepest beliefs, including a preference for private decision-making in a decentralized fashion. There are variations on the HMO theme as well. Most of these alternatives strive to place the patient and provider of care at some financial risk, thus making them more sensitive to the economics of medical care.

This movement away from fee-for-service—which is essentially an attempt to control the escalation of costs—usually involves the modification of two basic conditions of the traditional physician-patient relationship, as Professor David Mechanic noted in *Health Affairs* several years ago. First, these alternatives often seek to lock patients into a particular category of providers or restrict choice to a provider that becomes a gatekeeper to more specialized and expensive services.

Second, they modify the definition of the provider's role as sole agent of the patient's welfare to a role of balancing the patient's wants and needs against the aggregate population and a fixed budget. The physician or hospital role, thus, as Mechanic characterized it, is transformed from advocating to allocating. Such transformations are inherent in capitation, rate regulation and diagnosis-related group methodologies. While this change represents a major shift in the physicians's role, recognize that every health system in the world employs allocative mechanisms. Summing up the axiom of allocation, Mechanic said, "No system in the world is willing to provide as much care as people will use, and all such systems develop mechanisms that ration . . . services."

The United States has already adopted allocative mechanisms in a variety of forms that call for the rationing of services. Now, economist Victor Fuchs may say in response to that declaration, so what? He is of the strong view that the United States has always rationed medical care, just as every country always has and always will ration care. Nevertheless, what is news is a recognition, particularly in relation to Medicare, that the federal government has established new payment mechanisms that explicitly recognize limits on the availability of resources.

When Medicare was enacted, the federal government placed the financial risk for its operation squarely on the shoulders of government. With the enactment of the Tax Equity and Fiscal Responsibility Act, Congress shifted Medicare's financial risk from a total federal responsibility to one that it now shares with care providers and patients. This policy change represented a quantum leap in government thinking. Its willingness to place providers and patients at greater financial risk reflected the awesome federal budget deficit facing the government. It also suggested a willingness of government to move from implicit to more explicit forms of rationing. In the process, of course, government made certain that this responsibility was placed squarely on the shoulders of providers. As discomforting as that new role may be for physicians, where else would one logically place the awesome responsibility to decide how best to employ limited resources if there is a perceived need to adopt more stringent budgetary policies because of the insatiable demands?

Professor Jay Katz pointed out in his splendid book, *The Silent World of Doctor and Patient*, a better appreciation and, in turn, a better management of uncertainty will not emerge simply out of more refined technical knowledge, but must also engage the patient as well. Obviously the admission of uncertainty must be handled sensitively, given our litigious society. But with the increasing limits society is placing on the growth of medical spending, it is important that resources be spent on the most efficacious treatments.

The federal government obviously has an important role to play as well in identifying the best of what medical care has to offer. The National Institutes of Health currently spend \$7 billion a year to learn more about diseases and develop new tests and procedures. But it allocates relatively few resources to clinical trials and consensus conferences that seek to determine what of current medical practice works best. Strong arguments can be made that more trials, as expensive and time-consuming as they are, would be a sound investment of tax dollars. For the medical profession, helping to identify the most efficacious procedures would underscore its commitment to the physician-patient relationship.

The Health Care Financing Administration (HCFA) also is playing an important role in pressing the case for the availability of more and better information about medical care and those professionals who render it. Last year, HCFA released comparative hospital mortality data of institutions that participate in Medicare. While the data was unadjusted for the severity of patient illness and thus in many instances misleading, it nevertheless set a precedent that HCFA is determined to repeat this year and beyond. HCFA's administrator, Dr. William Roper, is committed to the release of this data and is seeking to improve its accuracy. Roper's commitment is based on a belief that the public finds appealing the concept that it know more about the performances of physicians and hospitals. Roper also is committed to the notion because he believes that a medical care delivery system based on market principles cannot function without knowledgeable consumers.

While market advocates are wedded to the importance of informed consumers, it would be a mistake to believe that once the Reagan Administration departs government the idea of providing more information to payers and patients alike about medical decision-making, efficacy and performance will disappear. The

commitment to this objective runs far deeper. It has been embraced by policymakers across the philosophic spectrum, private third parties and by the more enlightened leaders of organized medicine as well.

CONCLUSION

The public gives doctors special advantages and privileges in exchange for a commitment to place the public's interest ahead of any economic gain. As a consequence of physicians' abiding faith, the profession is largely self-regulated, self-credentialed and self-disciplined. It is unlikely over the coming decades that the essential equation that has long existed between the profession and the public will be overturned. The public, however, is demanding new forms of accountability from the profession. It is in meeting these emerging demands that the shape of American medicine in the 21st Century will take form.