EDITORIAL
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A BUM RAP FOR DOCTORS

Robert B Howard

Not so very long ago, we physicians were all heroes, or so it seemed. Marcus Welby and Ben Casey regularly performed miracles and epitomized all those wonderful virtues — knowledge, skill, integrity, dedication, and selflessness — that the public attributed automatically to members of the medical profession. National opinion polls ranked us second only to the members of the US Supreme Court in terms of respect and confidence.

How this has changed in a few short years! We have become villains, often depicted in terms formerly reserved for munition manufacturers or pimps. Public confidence in us has plummeted. We stand accused of insensitivity at best, greed or outright dishonesty at worst.

The dimensions of our new standing were brought home to me anew by a recent issue of USA TODAY! Its entire editorial page dealt with the issue of health care costs, and kind words about physicians were about as common as volunteers for brain. biopsy. Phusicians were pictured as greedy opportunists with no concern for spiraling health care costs.

Among those interviewed for the articles, a nurse reported that one doctor charged $10 for a procedure and another charged $24, a differential she characterized as "outrageous". "Regulating prices might reduce the gap," she said. A waiter interview said "It might be time for the government to intervene and set their own medical fees. I know the doctors won't like it but they already make enough money, don't they? A retired woman told the reporter, "Anyway it goes, doctors will still have to perform their services. This might knock their egos down to size."

A series of articles concerning the resurgent malpractice crisis in the Bulletin of the American College of Surgeons provides a different kind of insight concerning America's disenchantment with medicine. Longerbeam reviews the professional liability situation from a national perspective, citing both the increasing frequency of claims and the astronomical awards being made in a number of instances. An $8.4 million award was made in one California case, and one of $12.4 million in Florida. Longerbeam reports that in the latter state one in five physicians has now been invovled at some time or other in a professional liability lawsuit, whereas two decades ago only 1 in 20 had been so involved. In Massachusetts, in 1981 alone, ten claims were settled at the seven-figure level.

What accounts for this precipitous deterioration in our public image? How did Dr Jekyll turn into Mr Hyde so quickly? Not surprisingly, money is at the root of the matter. As health care costs reached the level of a sort of national tithe, public distress and outrage mounted. In predictable fashion, blame had to be fixed. Doctors were the most visible and inviting target, even though only a fraction of the responsibility can properly be laid at our feet.

One must concede at the outset, of course, that we are not blameless in this matter. The stereotype of the physician or surgeon as a Wednesday afternoon golfer more concerned about his Ferrari and tax shelters than about his patients did not become a stereotype without some small basis in truth. I have known of physicians like this. There are mercifully few, but they do exist.

The extremely wide range of fees often reported for a given procedure is puzzling and difficult to justify. The basis for the setting of fees often seems obscure, indeed. And it would be foolish to assert that unnecessary procedures are never carried out. We must be willing to assume our proper share of responsibility in this situation and to do everything we can to remedy those problems over which we do have control.

I almost always find public discussions of health care costs dismaying, however, in their failure to discuss in any meaningful fashion those elements over which physicians have no control and in the misconceptions this oversight conveys. For

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example, one of the USA TODAY contributors, Patrick Cox, trots out the old shibboleth that the medical profession controls the supply of doctors and has purposely kept their numbers down. The AMA has, of course, never had had this control, and the fact is that the number of medical school graduates doubled between 1965 and 1980 — with the active support of the medical profession. That this outpouring of additional physicians has failed to contain health care costs is self-evident.

Cox goes on to offer the free market as the "real cure." "Open medical schools to all who can pay their way," he says, and "let doctors compete and offer better services at lower costs." He has, of course, no concept of the extremely high cost of medical education, one very practical limitation to wholesale medical school enrollment. A more important flaw in his so-called cure is the fact that there is not the slightest evidence that the competition he envisions, centered around physician supply, will result in lower costs. Available evidence, in fact, suggests the opposite: More doctors result in higher costs because more services are rendered. The "need" for medical services is not sharp, distinct, or precisely measurable. It is a perceived need that comprises many services people would like to have but which do not really affect their health status in any material way. This need, therefore, can expand essentially endlessly in response to the number of available physicians and other health professionals.

This is not to say that competition has no role in attempts to contain health care costs, but the competition that may hold promise is not based on hordes of physicians hawking their services at curbside. Rather, it is based on organized groups of physicians competing for service contracts with various employee groups; this competition in no sense depends on the availability of an unlimited number of physicians.

Few articles on medical costs discuss in any substantial way what I consider to be the most important factor in their escalation, namely, the remarkable technologic advances that have been made. Open-heart and coronary bypass surgery, transplantation surgery, modern respirators, fiberoptic endoscopy, CT scanning — to name just a few of the more spectacular developments — have all wrought miracles, but the amount they have added to the health care bill has been as spectacular as the procedures themselves. It is obvious, though, that we are not going to abandon them because they are too costly.

Another cost factor seldom discussed in depth is the effect of our aging population. It is obvious that people are living longer and that a surprising proportion of us surviving into the eighth and ninth decades of life. As any physician well knows, the elderly become ill more frequently, and they get more complicated illnesses than the young. They require a disproportionately large amount of medical attention, including the technologies just mentioned. The proportion of total health care costs that is incurred during the final year of life is staggering. Some of this expenditure, in my view, goes only to extend already tortured lives for a few more agonizing hours or, at best, days. But how can we, as a society, arrive at a way to make the judgments necessary to cut down expenditure of this type?

The malpractice explosion takes its toll on costs in several ways. The size and number of awards have resulted in malpractice premiums well into five figures and nearing the six-figure mark for certain high-risk specialties. Imagine having to clear $50,000 or more per year in fees — after paying other professional overhead — before being able to take a dollar home! Even these mind-boggling costs, however, are propably of less consequence to the overall cost of health care than is the defensive posture the malpractice situation has caused us all to assume. I believe that the costs of "defensive medicine," the ordering of tests and consultations only to serve as a protection for the physician in the event of future claims, is extremely high, although difficult to measure with any degree of precision.

The cost of medical education has increased sharply and impinges on health care costs in many different ways, one of which is the direct effect on young physicians. It is not uncommon for today's physician on completing residency training at age 30 or 32 to have a debt of $50,000. Faced with this, plus malpractice insurance premiums of the magnitude discussed, other professional expenditures, and growing family responsibilities, it is little wonder that he or she sets fees that appear exorbitant to many.

Finally, the general inflation rate also has accounted for a segment of the rise in health care costs, a fact sometimes lost sight of. Salaries for hospital workers have increased, as have the costs for all kinds of supplies and equipment — not just the spectacular gadgets.

It is generally stated that health care costs have risen at a rate about double that of inflation. It is my belief that this difference can be quite readily accounted for by the factors I have discussed. It would be refreshing to see some discussions of this subject that deal with these factors and suggest ways of resolving them rather than simply giving more lumps to the medical profession.

EDITORIAL COMMENT

Much of the points made by Dr Howard are relevant to the Singapore context. We wish to thank Postgraduate Medicine for allowing us to reproduce the article in full. Perhaps it will stimulate some of our readers to put pen to paper and let us have their views.

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Editor