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A Physicians Council Symposium

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Restoring the Doctor-Patient Relationship

By Robert E. Moffit, Kevin Vigilante, and Sandra Mahkorn

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A Physicians Council Symposium

Restoring the Doctor-Patient Relationship: The Challenge of Third-Party Payment and Government Regulation

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ROBERT MOFFIT: On Capitol Hill and around the country, Americans are pondering the basis for renewing the debate on the American health care system. What is our starting point? Of course, with you, the members of the medical profession, the central issue is the doctor-patient relationship. Ideally, that relationship and its preservation should be the touchstone of reform. But not all agree. Some corporate experts feel that we ought simply to build reform on the basis of the current health insurance system—the employee-based, tax-supported insurance arrangements that have been with us since World War II.

But underlying the current insurance system are major market distortions. This is a fundamental fact of our economic life. It is the environment in which you, as physicians, currently operate. These market distortions serve to drive up health care costs while accelerating the rate of uninsurance among the working population.

What this means, ladies and gentlemen, is that if you insist on building upon the current insurance system, inescapably this means that you must close it up even more, to adjust for these distortions, and increase the already heavy role of bureaucracy and the regulatory regime that governs it. It also means reducing doctors and hospitals to the status of even more highly regulated public utilities. I think this is logically inescapable if the basis for new reform is simply the current employer-based insurance system.

Managed Competition. With last year's collapse of the Clinton plan, several states are experimenting with the latest versions of "managed competition," establishing the managed care networks inspired by the theoreticians of the Jackson Hole Group.[1]

Let us consider the current trends in private, employer-based insurance. Right now, in too many boardrooms of corporate America, our colleagues in the business community are celebrating what they believe to be a triumph of the free market. We are witnessing a mass movement of employees into managed care networks. Now, the rate of acceleration is nothing short of breathtaking. In 1992, no more than 15 percent of all Americans were enrolled in health maintenance organizations. Today, 63 percent of all workers are enrolled in health maintenance organizations, PPOs, or other managed care plans.

While, in fact, many representatives of corporate America see this as a triumph of the market, it is nothing of the sort—at least in the normal meaning of the market. Could you imagine a free market where there is no normal collision of the forces of supply and demand, even on the most basic level, which is the consumer purchase or sale of a commodity? Could you imagine a free market where the customer of goods and services is an entirely different personality from the consumer of those goods and services? Or could you imagine a free market where, for all practical purposes, the consumer of a good or a service has no property right in

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1 For a discussion of the managed competition approach to health care reform, see Robert E. Moffit, "Overdosing on Management: Reforming the Health Care System Through Managed Competition," *Heritage Lecture* No. 441, February 23, 1993.

the commodity—in this case insurance—that is bought and sold? Of course, you could not answer "yes" to any of these questions.

So it is really quite absurd to say that we are witnessing a triumph of the market when the consumer of the commodity—in this instance, health insurance—cannot personally buy it, when the consumer can have no property right in the commodity once it's purchased, and when the consumer cannot realize any personal savings in a free exchange by weighing the value of the commodity and the price to be paid for it.

The current mass movement to managed care, whether that form of care is a good idea or a bad idea, is not a triumph of the market. It is, however, the latest evolution of the current insurance system, which is a fundamentally distorted third-party payment system built upon a legally exclusive, tax-supported, employer-based model that frustrates consumer choice and competition.

Consumer Demand and Consumer Choice. In many instances, there is no consumer demand because, in fact, consumers are not even consulted by insurance companies about whether they would like to buy the product. Rather, corporate managers are deciding, for solid financial reasons relating to the company's bottom line, that they can no longer afford traditional indemnity insurance and are enrolling their workers in managed care plans. This is a transaction where the employer, not the employee, makes the key decisions and, at the same time, where the employer, not the employee, realizes the savings.

If the managed care plan is less expensive than the conventional corporate insurance plan, this amounts to a reduction in the worker's compensation. Too many Americans do not yet clearly understand this. The reason: Too many Americans think, wrongly, that the employer's contribution to their company's health benefits package is the employer's money and not the employee's money. I personally know of no instance where corporate benefits managers are giving workers cash back in an amount equal to the difference, say, between the higher cost of last year's indemnity plan and the lower cost of next year's new managed care plan. Whatever the impact of the managed care revolution on the quality and delivery of health care services, this is very often an employer, not an employee, decision. This should be the subject of extensive congressional debate. Unfortunately, it is not; at least, not yet.

The new managed care revolution brings with it two related problems. One is economic. The other, more important problem is political.

In the transition from fee for service to managed care plans, there is likely to be—and the preliminary studies bear this out—a transitional savings to employers. The existing professional literature indicates that this is the case. The economic problem is that there is no guarantee that managed care, whether in the form of a staff model HMO or other managed care options, will contain long-term health care costs. According to a 1993 GAO report on the subject: "Although many employers believe that, in principle, managed care plans save money, little empirical evidence exists on the cost of savings and managed care."

But that is not the most important problem. The more serious problem is political; and it is a political problem at the direct expense of managed care. Lest I be misunderstood, I am not an opponent of managed care. I am only saying that individuals should be personally free to choose or reject it, and that government policy on the issue should be strictly neutral. Managed care, in fact, is not being given a fair shot in the free market because there is no free market. This is bad for managed care. When employees are forced into managed care plans without other options, or against their will, they not only have been deprived of a choice of their health plan, but they also are deprived of their choice, in many instances, of a doctor or a medical specialist.

In other words, Americans will have even less choice over their health care decisions than they have today. If popular dissatisfaction with employer-based insurance grows—as it surely will, especially with the higher number of uninsured and an expected rise in health care costs, which we may see again, perhaps at the end of this business cycle—this popular dissatisfaction can threaten the entire private health care system.

Advocates of a Canadian-style system have had a rather difficult time selling the notion that monopoly is really good for you, or that government monopoly is even better. Or, as my colleague, Dr. Stuart Butler, Heritage Foundation Vice President, suggests, try to imagine that your health care future is going to be bright and cheery when it is run by those thousands of eager public servants ready to answer your every call or help you with any question over the phone down at the local government clinic.

But advocates of the Canadian-style system can make an excellent case in saying, "You may not like the Clinton plan or its various congressional incarnations, and you may not like government-run health care, but at least, under a Canadian-style system, you will retain your right to a physician."

The End of Private Practice? That is, for most Americans, a powerful argument. It's a clincher. It can also mean the end of private health insurance, and I submit to you that if it's the end of private health insurance, it is really the end of private medical practice. Private practice cannot survive outside of private markets.

This morning, we have two physicians who are going to talk about this vital issue: the doctor-patient relationship.

Kevin Vigilante, M.D., comes to us from the Miriam Hospital at Brown University in Providence, Rhode Island. He is the clinical partner in the Miriam Immunology Center. Kevin cares for women with HIV and started a community outreach clinic to provide health care to women coming out of prison. He has been the principal investigator in an NIH study to determine the effects of early treatment of HIV infection with AZT. He has also been the principal investigator on the Ryan White grant to provide HIV prevention and care. He has been the Director of Emergency Medical Services and Clinical Assistant Professor of Medicine at Brown University. He has been the Director of Primary Care and Instructor of Medicine at Yale University.

Dr. Vigilante is a graduate of the Harvard School of Public Health and Yale University's Internal Medicine Department. His M.D. is from Cornell University. He got his master's degree in bacteriology from Wagner College, and he got his bachelor's degree at Johns Hopkins University in philosophy and political science. This past year, Dr. Vigilante ran for the U.S. House of Representatives against Congressman Patrick Kennedy, garnering 46 percent of the vote.

Sandra Mahkorn, M.D., serves as Chief Medical Officer of FHC Managed Care Health Services in Norfolk, Virginia. Before assuming that position, she was a Clinical Assistant Professor and Satellite Clinic Medical Director for the University of Wisconsin in the Wisconsin Medical School.

In the Bush Administration, she served in two capacities: first, as the Deputy Assistant Secretary for Public Health Policy of the Department of Health and Human Services between 1991 and 1992, and second, during the last several months of the Bush Administration, with Vice President Dan Quayle on the White House staff. She was an Associate Director for the President's Council on Competitiveness.

Before her White House appointment, Dr. Mahkorn was the lead physician at the Oxnor Clinic in New Orleans, Louisiana. She is a member of several medical associations and holds

a master's degree from the University of Wisconsin in Milwaukee in educational psychology and urban affairs and a master of public health degree from the Tulane School of Public Health and Tropical Medicine. She received her M.D. from the University of Wisconsin at Madison.

I turn you over to Dr. Vigilante.

THE ETHICAL IMPERATIVE

KEVIN VIGILANTE: Thanks very much. It's great to be back here at the Heritage Foundation. It is always a pleasure to work with brilliant people, and I have been a fan of the innovative Heritage approach to solving our health care dilemma for quite some time.

I was asked to come and talk about the physician-patient relationship. I think it is probably the most precious thing we have in the practice of medicine. Most of us did not choose to do what we do because of money, but because of some other, more important sources of gratification. I think that in this whole national health care debate, the physician-patient relationship has not had adequate attention.

And it is undergoing a tremendous change. Go back to the Hippocratic Corpus, 2,500 years ago. We Hippocratics call it the Hippocratic Corpus because it was written by a number of different people. Hippocrates, the great Greek philosopher, only wrote a small portion of it, and like any piece authored by multiple people, it has its share of contradictions, inconsistencies, and differences in style.

But one thing throughout the entire Corpus is constant: It is the physician's primary duty—actually, his sacred duty—to serve the patient. It puts the physician clearly in the servant role.

That is the ideal. Throughout ancient and modern history, that tradition endured right up until the present time. True, you can find exceptions, such as the Great Plague, where some of the best and brightest physicians fled the towns and cities to leave their patients behind to be cared for by lowly "plague doctors." But that was an exception.

We all know physicians who are, perhaps, pompous and arrogant, and thus do not typify the notion of the servant. But, again, that is a deviation from the ideal.

Under this model, it is the patient's prerogative to leave the physician at will, for whatever reason, without explanation. But, ethically, it is not a reciprocal relationship. The physician can never leave the patient at will, or abruptly. That, according to the professional ethic and the law, is called abandonment. The physician must subordinate himself or herself to the needs of the patient in a service capacity.

What has happened recently, very recently, is that for the first time in the last 2,500 years, on a large scale, that relationship has started to change. In a very subtle, insidious, and somewhat unrecognized way, it is changing, and we are seeing corporate medicine, managed care medicine. It is a change from a dual relationship to a triadic relationship, where the physician is no longer employed by the patient. The physician is now employed by a corporate entity.

A physician has two functions in that regard. He has to care for the patient, but he also has to meet a financial or cost objective established by the corporate entity. So what was previously a very unambiguous relationship with the patient has become conceptually blurred. Where does the physician's loyalty lie?

Most of us, and most of our colleagues, are going to go on practicing largely the same as we did before. We have a strong feeling that the ethical imperative is to be responsible first to

your patient. But like all such changes, at first imperceptible and insidious, these things have gradual influence, and in subsequent generations, I fear we are going to see a change in physician behavior. This is borne out, I think, most acutely or dramatically in the concept of futility. Somebody mentioned last night at dinner that the last few months of life are the most expensive when we're under care.

There is a raging debate in the realm of medical ethics called the problem of futility. When you have somebody who is in the last days and months of life, undergoing extraordinary methods of treatment, and the physician feels that this is futile care, that this will not change the ultimate outcome of this person's life, who has the right to withdraw treatment? Is it the physician unilaterally? Is it the physician in consultation with the family, particularly if the family wants everything done?

In the old model, you could have a debate as to whether the physician had some right in saying, "I'm not obliged to deliver all forms of treatment—I can withhold some treatments based on professional judgment." But now there is a third factor in this decision, not related to the physician's professional judgment as to whether this care is futile or in accord with the family's wishes. It's the pressure that the managed care corporation brings to bear.

Their bottom line is precious; and if the last six weeks, or six months, of care is responsible for the majority of their cost—well, who is going to be making decisions about futility, and where are the pressures going to come from? And when there is uncertainty, when do you come down on one side or the other? This is very, very important ethical territory. We cannot avoid it.

So I am very concerned about the corruption of the physician-patient relationship. Again, let me just say one thing: I am not anti-managed care and I am not anti-HMO. Some of my best friends work for HMOs, and they're good doctors. Harvard Health is in my territory, and I'd be proud to practice medicine there. It's good medicine. But you know, there's the good among HMOs, there's the bad, and then there's the ugly. And it's not always easy to tell, especially if you're a lay person, which is which, or what it's going to be five years from now.

Personal Choice. The solution to this problem, to this dilemma, is choice. Give the patient the choice of saying, "Yes, I want to be a part of that HMO and that doctor," or, "I don't. I would prefer to be a part of that HMO, or managed care, or PPO, or neither. I want to go to somebody else completely outside the managed care structure."

That is the essence of it. Because once you've done that, you've empowered the patient. He can make the decision as to how much ethical ground he's going to trade in for cost savings, and it's his choice. Right now, it's the employer's choice because the employer says, "Look, I'm getting the best deal from X Y Z managed care down the road. So you don't get so many MRIs. However they're doing it, I don't care. They're saving me money. That's who you're going with." For employers and their doctors, that's a real problem.

The reason why employees don't have choice is simple: the tax code. It is because the only way you can get a tax break is if your employer buys the policy for you. And that's nuts.

Most people still don't get it. They don't realize that right down there in the bowels of the system is this one small, invisible tax lesion. It's like a genetic error. It's very tiny; it's very small; but its effects are protean, and it's passed on from one generation to the next. Unless you identify that gene, you will not fix the disease.

But this is more invisible than any gene, because nobody is out there getting NIH grants to look for it. Unless you change the tax code, you're not going to fix this problem. And that's

the importance of what the Heritage people were saying years ago: "Fix this lesion." If you do that, the American health care system will be in a position to pick up its pallet and walk.

The other thing that is very important is medical savings accounts (MSAs). MSAs provide an ethical, as well as financial, counterweight to corporate managed care because with an MSA, you are dealing, for much of your care, in cash, and cash goes anywhere. It's your choice as to where to bring it. Nobody says you can't go here or go there. It preserves the possibility of a fee-for-service environment and opens up possibilities for other forms of care. And it injects price competition, real price competition, into the marketplace. The only way a consumer can tell what something is worth economically is price. That's what prices are for.

So I conclude by warning that the traditional physician-patient relationship is under threat. This very emotional, precious relationship is under threat from a very arcane and technical marauder: a few lines in the federal tax code. For too many policymakers, there is a cognitive disconnect here; you almost can't believe it. Unless we focus on it, we will not be able to heal our health care system or salvage the doctor-patient relationship.

A MODERN FABLE

SANDRA MAHKORN: I'd like to tell you a story about Dr. Goodfellow, who lives and practices in Home Town, U.S.A. Dr. Goodfellow finished his internship in 1963 and set up a simple general practice. He hired a medical assistant and a receptionist and worked hard, often seeing as many as thirty-five to forty patients a day.

A large factory in Home Town shut down, and Dr. Goodfellow saw about five or six patients a day for free during the local economic crisis. Many of these were older and retired people, and he knew they'd have a hard time paying their bills.

Dr. Goodfellow knew his patients very well, and so did his medical assistant and his receptionist. He loved medicine, and he loved being his own boss, a trait that he had inherited from his father, who ran a small family grocery store. In the evening, Dr. Goodfellow often spent an hour or so going over books and catching up on his paperwork, and at the end of the day, he went home to find his two children watching "Leave It to Beaver" and to enjoy a good, home-cooked meal.

He worked long days, and sometimes nights, but he was happy. He felt good about what he did, and he knew his patients liked him and believed in him.

The years passed quickly. One morning after coming to the office, Dr. Goodfellow paged through his 1995 calendar. August 8 was a day he had circled in red. He would turn fifty-nine-and-a-half on that day, and he could withdraw money from his IRA without penalty. Should he retire? He never thought he'd want to consider that option so soon, but things had changed.

"Oh, well. I'll think about it a little more," he decided. Then he grabbed his white coat and stethoscope, and entered the examining room of his first patient.

"Hello, Mrs. Adams. I'm Dr. Gatekeeper—oh, I'm sorry. I mean, Goodfellow. I see you're a new patient with Happy Health HMO. Can I do anything for you today?"

Mrs. Adams pulled a long strip of paper from her purse. He sank onto the swivel stool, prepared for a long session. "Well, I've been seeing a dermatologist for this rash and an allergist for these awful sinus problems I have. And I have some urinary problems, so I see this nephrologist. So if you'd just write me some referrals, I'll be on my way."

"Why didn't the HMOs ever tell patients they'd have to get most of their care from a family doctor?" thought Dr. Goodfellow. He resented being put in the middle.

Dr. Goodfellow's staff had grown with the years and the hassles, and he now employed a registered nurse, a file clerk, a receptionist, and a medical assistant. Besides that, he contracted with a billing service, an answering service, and medical transcriptionists. Not infrequently, he was forced to hire a lawyer. He was also forced to hire consultants to help him decipher new regulations, such as OSHA and CLIA.

Last year, the overhead alone was over 60 percent, and his income had dropped. Dr. Goodfellow now had time to see only about eighteen patients a day. Some days, it seemed as though the paperwork took the bulk of his time.

New Medicare regulations had just been published. "Well, I guess that interesting article on new treatments for rheumatoid arthritis will just have to wait," he thought. A few years ago, he had neglected to keep up with some regulations regarding Medicare billing, and several patients left his practice after receiving nasty-sounding letters from the federal government that made it seem as though he was fraudulently charging them.

He walked into the next exam room. Mrs. Williams hadn't noticed him come in at first. Her forehead was barely visible behind the latest issue of *Ladies Health Journal.* Dr. Goodfellow's mouth dropped a little bit when he read on the front cover of the magazine, "What Your Doctor Doesn't Know Can Kill You." As Mrs. Williams slowly lowered the magazine that she had picked up in his waiting room, Dr. Goodfellow detected a sense of anxiety in her expression. After spending half an hour convincing her that he really did understand the side effects of Robitussin DM, he ordered all magazines removed from his waiting room except for *Road and Track* and *Plumbing for Amateurs.*

He was about to see his third patient of the day when the receptionist paged him to take a call. It took him twenty minutes to explain to Happy Health HMO's utilization review expert why Mr. Cardiac, a 52-year-old business executive in congestive heart failure and a four-day-old coma, wasn't a candidate for early discharge on a home respirator.

Even though his office staff had swelled, it seemed as though the number of things he was able to do in his office had dwindled to nothing. Last year, he discarded the strep screens he had been doing and placed his cholesterol monitor in storage after registering as a waivered lab under CLIA—the Clinical Laboratory Improvement Amendments. He continued, however, to secretly perform Gram stains from time to time, something he had learned in medical school. In his heart, he felt he really had a right to provide that service to his patients.

He kept his microscope in a locked cabinet in a dark corner of his office. One day, a disgruntled employee discovered the Gram stain reagents he had forgotten to replace in the desk drawer and called the CLIA police. The next afternoon, an officious-looking gentleman stormed into his crowded waiting room flashing a badge, while anxious patients looked on. Intimidated, he escorted the surly inspector to his office. His microscope, a bottle of Crystal Violet, and his microbiology texts were all confiscated. "You know, you could be fined $10,000 for this," said the inspector as he bagged up the evidence.

Finally, it was lunch time. He grabbed a bagel that had been left by a drug detail man and jumped into his car. The hospital had called a meeting to discuss the new PHO they were forming. The idea sounded good until he read the fine print.

The afternoon schedule was almost as challenging as the morning's. Exhausted, he was about to leave the office when the hospital's patient advocate called. "Mrs. Macintosh was irate," she explained. "She insisted she had not given informed consent for the two metal sta-

ples to be used in place of the two silk ones after her laparoscopy. She's threatening to sue, and her attorney wants you to call him."

"Tell Mrs. Macintosh I'll speak to her about it in the morning," sighed Dr. Goodfellow wearily and apologetically.

Patient advocates. Every hospital has them now. "Strange," he thought. "There was a time I thought I was the patient advocate."

He shuffled into the den after a long ride home. His grandchildren were at first oblivious to his presence, watching "Beavis and Butt Head." Finally, his granddaughter bounced onto his lap: "Grandpa, guess what? I've decided to become a doctor."

The Moral of the Story. The Dr. Goodfellow story illustrates several factors that have contributed to the disintegration and dissolution of the physician-patient relationship.

First, there has been a revolutionary transformation in the medical marketplace resulting in a dramatic shift in the way we interact and view ourselves in relation to our patients. The helping relationship has been replaced by a contractual relationship. Instead of doctor and patient, it is now provider and consumer.

Second, the third-party payer has taken on a directive role. Rather than passive players, as was the case with traditional indemnity plans, physicians and patients are the subjects of behavioral management strategies. Reimbursement schemes and monetary incentives are designed to elicit defined health care decision responses. Not only must the physician and patient consider the medical pros and cons of alternative treatment, but other factors must be considered. For example, should the 60-year-old woman who has been doing well on a particular blood pressure medicine that is no longer on her HMO's preferred drug formulary risk changing medications to avoid a higher copay?

Third, since PPOs and MCOs discourage or prohibit the use of providers not listed in their panels, the doctor-patient relationship has been supplanted by the patient-HMO relationship. It's no longer "my doctor," but "my HMO."

Fourth, the media have not been particularly kind to the physician. Perhaps it's the anti-authority inclination; perhaps it's a bit of muck-raking. Doctors are not above being questioned. Nor should they be immune to legitimate challenges. But the challenge often takes the form of an attack. Articles such as "What Your Doctor Never Learned in Medical School" abound and undermine former trust.

Finally, federal and state governments have stepped into the physician's office to regulate the practice of medicine. Under the Clinical Laboratory Improvement Amendments, for example, physicians who choose to do a simple strep screen or read a Gram stain are faced with costly and burdensome regulatory requirements. Regulations promulgated under the guise of protecting the public too often have been the products of scientifically baseless political grandstanding. A 1994 study in the *Journal of the American Medical Association* found that strep screens could be performed by sixth graders, with an average IQ of 90, with 95 to 100 percent accuracy on the first attempt. Yet the government considers strep screens so complex a test for the physician that expensive regulatory burdens are required to protect the public.

There is probably no turning back, but where do we go from here? As physicians, we must take an active role in deciding our futures. In many cases, we may be employees. But the health system can't function without us, and therein lies our strength. We have a responsibility to our patients to preserve their health care choices. And we have a responsibility to ourselves to preserve our decisionmaking options.