EDITORIAL

Is medicine a profession or a business?

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The question of whether medicine is a profession or a business has been under consideration for many years, generating divergent opinions, which have created more than a small amount of controversy. It would be expected that for individuals—from the health care academic, to practitioner, to patient, and, very likely, to any person on a street corner—there are often strong emotional opinions about this matter.

In April 2014, I was asked to do a presentation on this subject in Warsaw, Poland. The conference was entitled, "Ethical Dilemmas in Physicians Practice: Are the Business and Ethics of Medicine Compatible?" This article highlights some of the content of that presentation. The objective of the article is to present some history on this critical issue and to review the bearing that certain events have had on medicine as a business. Herein, I will also address the current status of control of health-care delivery in the United States.

As long as there has been the practice of the healing art, which we now call "medicine", there has been an economic component to the interaction of the practitioner and patient. In America, as modern medicine began to adopt the scientific method, physicians have developed increasingly helpful interventions and enjoyed a place of great public respect. The practice of medicine has, in fact, always had a business component. The business of medicine, or in the largest sense, the business of health care, was little more than the transaction of service and payment between the physician and patient. No person living in the late 19th century could possibly have foreseen the exponential growth of knowledge, technology, and regulatory initiatives that would ensue over the next 100 years, during which time the complexity of the business of medicine has escalated.

Maggie Mahar, in the opening chapter of her book, *Money Driven Medicine: The Real Reason Health Care Costs so Much*, notes, "Throughout most of the 20th century, the nation's physicians won the battle to control American medicine. For decades, they held virtually unchallenged economic, moral and political sway over what we now call the 'health care industry'".[1] Contrast this with an editorial published in 1970 in *Fortune*, which declared: "The time has come for radical change… . The management of medical care has become too important to leave to doctors, who, after all, are not managers to begin with".[2] How did this change come about?

Let us begin by examining some World Health Organization's data on health-care spending in several countries.[3] The numbers reflect spending by a country as a percentage of the gross domestic product (GDP). The United States spends roughly double the percentage of its GDP on health care (17.6%) as compared with Canada (11.4%), the United Kingdom (9.6%), and Poland (7.0%). Considering the staggering sum of money spent in the United States (2.7 trillion dollars in 2010), one might reasonably conclude that American citizens would be the healthiest population on earth. Correct? Sadly, this is not so.

FIGURE 1 outlines health-care spending, again as a percentage of the GDP, represented over time from 1965 to 2010.[4] The figure shows that health-care spending has increased from under 6% to almost 18% of the GDP. The World Health Organization publishes global data on the measures of population health, gathered from extensive reporting from most countries around the world. The United States continues to rank much lower than one would expect, compared with other industrialized countries where much less of the GDP is spent on health care. With all due respect to the many legitimate debates that could be entertained regarding these data, it must be recognized that there is an overwhelming disconnect between health-care spending and the modest health benefits experienced by citizens in the United States.

FIGURE 2 represents health-care spending and health outcomes in the United States. It is clear that, at a certain point in spending, there begins to be diminishing returns on that investment. As spending continues to increase, there are ultimately negative outcomes in health measures. There are no numbers on this graph, as it is impossible to determine exactly what expenditure results in diminishing marginal returns. The concept, however, is that as more resources

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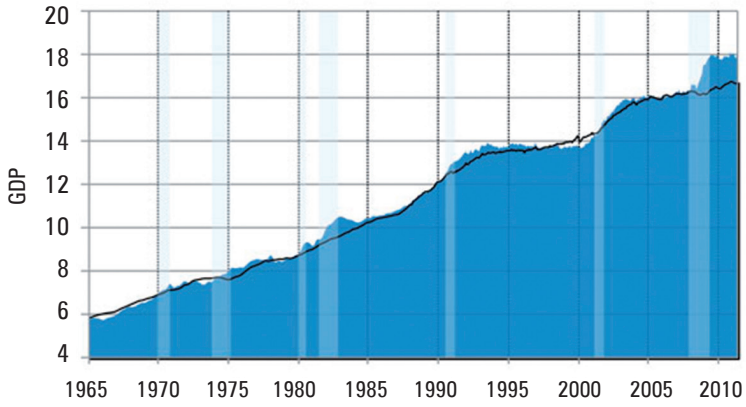

FIGURE 1 Cost of health care in the United States as a percentage of the gross domestic product (GDP)

are being spent on health care, the population in many respects is becoming unhealthier. One cannot look at this information and avoid asking the simple question of who is at the helm of this national problem. In other words, "Who is driving this bus?".

There are many stakeholders in the game. With trillions of dollars at stake, the positioning for power is intense and can be vicious. The government plays the largest role and has the lion's share of money under its control. The insurance industry has an enormous influence and exerts significant control over expenditures. Drug companies are major players vying for control. Increasingly, Wall Street investment bankers are in control of large sectors of health care including facilities and even physician practices. In my own specialty—emergency medicine—a very few, very large Wall Street investment entities own a significant proportion of emergency medicine practices in the country. James Keaney, MD, has written eloquently about this in his book, *The Rape of Emergency Medicine*, in 1992.[5] This trend towards the corporatization of physician practices now involves many other specialties. Other stakeholders in health-care delivery are health-care facilities including hospitals, nursing homes, long-term care facilities, rehabilitation facilities, as well as a large number of outpatient facilities such as imaging centers and surgery centers. Physicians are also stakeholders; however, regrettably, physician input in health-care leadership has a troubled history.

I will refer to a few significant dates in American history, which may help explain the lost opportunity for leadership by physicians, such that we now find ourselves quite marginalized in the capacity to lead. The dates in question are 1935, 1965, 1980, and 2012. Let us look at each one in turn.

In 1935, an insurance plan known as Blue Cross was initiated by the Baylor Medical Center in Dallas, Texas. Following this, in 1937, Blue Plan executives from around the country met in Chicago and formalized what would become the large national insurance company known as Blue Cross. While Blue Cross only covered hospital-related expenses, this was followed shortly by Blue Shield that would cover physician charges. It must be remembered that employer-sponsored health care began during the years of the Great Depression. In 1935, President Franklin D. Roosevelt voted against the inclusion of the national health insurance when he signed the Social Security Act. Yet, this same president later called for health-care insurance for all Americans, "cradle to grave", in his 1944 State of the Union Address. Many private health insurance companies arose during those years and employer-sponsored health care helped to supplement the wage gap after the Great Depression and World War II. The American Medical Association (AMA) watched these developments with a wary eye, concerned that this type of health-care funding had a risky future. Here was a time when physicians had the unique opportunity to step forward with their own comprehensive plan for the funding and delivery of health care for the nation. It did not happen. The AMA chose to watch carefully and advocate not for a comprehensive plan but rather for the welfare of physicians and their billing practices. A magnificent opportunity to lead health care into the future was overlooked.

Leap ahead to 1965. President Lynden Johnson proposed and passed the Medicare legislation for the provision of health benefits to citizens over 65 years of age. This landmark piece of legislation was, as might be expected, extremely controversial and difficult to pass. The effort to pass Medicare was started by President John Kennedy in 1962. During this 3-year period, the AMA launched an aggressive national campaign to resist and block the passage of the legislation. The AMA had reasonable objections to many parts of the legislation. The costs of the program were grossly underestimated, and reimbursement methodologies were structured such that uncontrolled inflation was almost ensured. The AMA mounted a massive campaign to oppose this legislation. The idea of providing health care to the elderly was not the issue so much as the form of this legislation. Here was a second opportunity in modern history where physicians, acting under their national organization, had an ideal window of opportunity to propose an alternative, comprehensive plan for the funding and delivery of health care. And for the second time, there was no plan proposed.

Leap forward again to 1980. Ronald Reagan was elected President. He entered office with a free market notion, which he believed would solve the nation's economic problems. It is somewhat an oversimplification of "Reaganomics" but President Reagan believed that, in the government, "less is more". The notion was that the government should reduce regulation and control, and that, in giving free reign to business, competition, productivity, and quality would increase by the necessity of market survival, and lastly, consumer response would reward those who produced better products with better prices. Unfortunately, health care does not behave according to market forces as does "widget" manufacturing. During President Reagan's term of office,

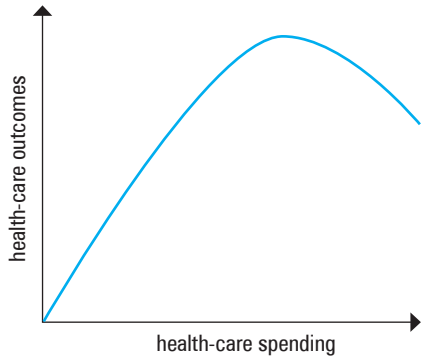

FIGURE 2 United States health care expense and health outcomes

health-care spending rapidly increased, and, conversely, the measures of publich health began to erode, as shown in FIGURE 2. In retrospect, it is clear that the business of medicine does not follow the rules that one would expect of any other business. Once again, there were ample voices of reason within the national physician community who were speaking out. The AMA once again, representing the country's physicians, had another opportunity to propose a national program for the funding and delivery of health care, recognizing that health care is a unique world of business. For the third time in history, physicians failed to respond to the call.

Last leap forward, to 2012. President Obama completed his agenda to pass the Affordable Care Act (ACA). The controversy surrounding this legislation has received worldwide attention. This is one of the most complex and costly acts of the government in human history. While the goal of this ACA is laudable, the complex details of the legislation caused many physicians to react in strong opposition. The AMA initially reacted loudly and negatively, not to the intent but to a multitude of provisions which were perceived as problematic. The costs of the program were likely underestimated, specific details of the plans to be offered were not provided, the breadth of services covered were not specifically outlined, and there was great concern about the volume of expected new patients not having physicians available to provide care. Here again, and I strongly suspect for the last time, was the opportunity for physicians, with their national voice, to present an alternative comprehensive plan for the funding and delivery of health care. It did not happen. In the final analysis, the AMA issued an endorsement of the ACA, in its entirety.

With this series of missed opportunities for physician leadership, it is little wonder that the AMA has lost a great deal of credibility, both with the public, and sadly, its diminishing membership, many of whom see the organization as representing its own interests rather than those of the patients or physicians.

Of course, there is ongoing positioning for power and control of the various stakeholders. The opponents of physicians having leadership, control, or ownership usually cite the argument of the "conflict of interest". The presumption is that where physicians were to be in control or even worse, in ownership, they would be inclined to overutilize everything under their control for financial gain. It is all too easy to recall cases where this has been the case. However, let us think clearly about the conflicts of interest regarding all of the stakeholders in leadership, control, and ownership. Can any reasonable person not cite conflicts possible for governments, insurance companies, drug companies, and all of the facilities mentioned earlier? As an intellectual exercise, I asked an academic colleague to reflect on this question. I asked that she take a few minutes and make a list of possible conflicts of all the stakeholders. Needless to say, this instant list was pages long. There is simply no stakeholder in the business of leading health care who is not conflicted! Conflicts are ubiquitous and must be "managed". The key to management is transparency.

Since the Reagan years, health care in America has become "corporatized" but is experiencing runaway costs and very poor return on that investment. A former editor of the *New England Journal of Medicine*, Dr. Marcia Angell, describes this disaster: "Private insurers regularly skim off the top 10 percent to 25 percent of premiums for administrative costs, marketing and profits. The remainder is passed along a gauntlet of satellite businesses—insurance brokers, disease--management and utilization-review companies, lawyers, consultants, billing agencies, information management firms and so on. Their function is often to limit services in one way or another. They, too, take a cut, including their own administrative costs, marketing and profits. In the end. As much as half the health-care dollar never reaches doctors or hospitals".[6] Dr. Angell penned this article in 2002. After the ACA becomes fully implemented, this problem may well be significantly worse.

I must say a few words about the commonly misunderstood concept of for-profit vs. not-for--profit medicine. Let us be clear about the difference. Not-for-profit hospitals do not pay property, state, or federal tax. Any profit, or "surplus" as those in the not-for-profit world prefer to call it, cannot be distributed to owners. Prior to the 1960s, a very small percentage of hospitals were breaking even, let alone making a profit. The freedom from paying taxes was perceived to allow the not-for-profits to provide care to the uninsured and underprivileged. I refer the reader to Maggie Mahar's excellent chapter on this in *Money Driven Medicine*.[1] The not-for-profit world of health care operates by virtually identical practices as the for-profit world. In fact, one of the wealthiest hospital systems in the world is a not-for-profit in Texas. Market share control is the number one motivator of all health care in 2014. In any given market, a for--profit provider may in fact provide more "charity care" than a competing not-for-profit one. A 2005 study published in the *Archives of Internal Medicine* examined advertising done by academic (not-for-profit) institutions. The study

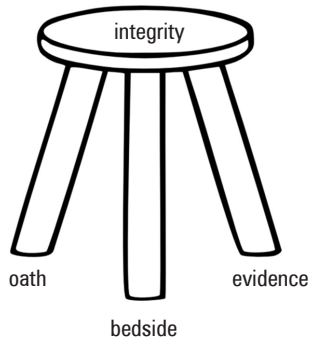

FIGURE 3 The concept of integrity stool in physician leadership

concludes "Ask the CEO of virtually any not for profit hospital and he will tell you: 'No margin, no mission'."[7] Profit or surplus, by whatever name one chooses, is the priority of both types of the health-care models.

With these unfortunate realities in mind, and recognizing the economic and health-care problems looming on the horizon, it is time to revisit who might do a better job of leading the country out of this dire situation. It is obvious that the stakes are immeasurably large, and no stakeholders will easily accept the change. It is, however, my contention that physicians should be aggressively taking the lead in bringing about the change. This article is not intended to advocate for the virtues of any health-care system over another (socialized medicine vs. multi-tiered socialized medicine vs. private insurance systems). The contention here is that, in whatever system, physicians should lead. Why should physicians lead?

I consider physician leadership to be understood as a three-legged stool of "integrity" (FIGURE 3). It must be understood that if any leg of a three-legged stool is missing, collapse is immediate. Such is the case regarding the "integrity of physician leadership".

The first leg to be considered is the oath that the vast majority of physicians in the world have taken on completion of training. The Hippocratic Oath has undergone a number of revisions, and, while not always the same at every institution, contains the common elements. The most frequently used oath was constructed by Louis Lasagna in 1964 during his tenure as Academic Dean of the School of Medicine at Tufts University.[8] The oath contains a pledge to place the interests of patients, both individually and collectively, above one's own. This sacred oath is the very heart and soul of the practice of medicine. I believe that the oath to serve patients collectively is in fact the promise to lead and direct the delivery of health care. Realistically, not every physician pays homage on a day-to-day basis to this pledge, but it is nevertheless our pledge. No other stakeholder makes such a pledge. It is nothing short of laughable to imagine an insurance company executive making such a pledge. Self-interest reigns supreme among stakeholders in health-care delivery.

The second leg of the "integrity stool" is the "bedside". Those of us in the clinical practice of medicine have the special privilege of being at the bedside of patients every day and sharing with them the best of our clinical judgment, and together make the most important decisions they will ever make in their lives. We do this day in and out for years. There is no other health-care stakeholder having any experience that approximates this. This sacred privilege and honor, in which patients place the trust of their lives with physicians, is unique and precious. It is physicians alone who have this honor.

The third leg of the "integrity stool", I refer to as the "evidence". The development of evidence-based medicine[9] over the last 30 years is nothing less than revolutionary in the practice of medicine. This brilliant concept has developed a science by which physicians now have the ability to evaluate the quality of information, and of even greater significance, a scientific method to know what we do not know. Evidence-based methodology is perhaps the most important development in modern medicine and is in fact the third leg of the integrity stool that allows it to stand. Prior to evidence-based methodology, medical "knowledge" was much more likely to be based on convention and experience. While evidenced-based methodology is not uniquely available to physicians, it is uniquely used by physicians in conjunction with the other legs of the integrity stool.

Health care in America is in a very precarious place at present. Never in history has it been more important for physicians to take the lead. The integrity of leadership as proposed above has the possibility of playing important role in redirecting the delivery and funding of health care. It is likely that when physicians act on a regional basis, in response to local needs and problems, that the seeds of change may have a chance to sprout. Co-operation for the common good must overwhelm the competitive environment, which is our current experience. This must also be accomplished while encouraging and rewarding ingenuity.

Maggie Mahar, in the closing chapter of *Money Driven Medicine* makes the following statement, "There is much to regret about the loss of the world I described in chapter 1, when physicians held sway over what we now call the health care 'industry'. This is not to say that anyone would wish to return to the day when the individual doctor reigned sovereign. The Lone Ranger Who Is Always Right is an anachronism. Today, forward looking professionals realize that they must collaborate, to create the evidence-based guidelines needed to shape best practices in the century ahead."[1]

The time for physicians to lead is now. Let us be grounded in the "oath", empowered by the "bedside", and informed by the "evidence". Therein is our hope for the future.

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