Toward medical dystopia

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I am a general surgeon with more than three decades in private clinical practice. Since the late 1970s, I have witnessed remarkable technological revolutions in medicine, from computed tomographic scans to robot-assisted surgery, but I have also watched as medicine slowly evolved into the domain of technicians, bookkeepers, and clerks.

Government interventions over the past four decades have yielded a cascade of perverse incentives, bureaucratic diktats, and economic pressures that together are forcing doctors to sacrifice their independent professional medical judgment and their integrity.

THE ADVENT OF CODING

At first, the decay was subtle. In the 1980s, Medicare imposed price controls upon physicians who treated anyone older than 65 years. Providers were required to use a coding system to describe the service when submitting a bill. The regulators believed that standardized classifications would lead to more accurate processing of Medicare claims.

Instead, it made doctors and hospitals wedge their patients and services into predetermined, ill-fitting categories. Medicare has used this coding system to maintain its price controls for more than 20 years. Private insurers, starting in the late 1980s, began pegging their compensation contracts to the Medicare code-based fee schedule, effectively extending Medicare price controls into the private sector.

The coding system was supposed to improve the accuracy of adjudicating claims submitted by doctors and hospitals to Medicare and later to non-Medicare insurance companies. Instead, it gave doctors and hospitals an incentive to find ways of describing procedures and services with the cluster of codes that would yield the biggest payment. Today, most doctors in private practice must use coding specialists, a relatively new occupation, to oversee their billing departments.

Another goal of the coding system was to provide Medicare, regulatory agencies, research organizations, and insurance companies with a standardized method of collecting epidemiologic data. However, the developers of the coding system did not anticipate the unintended consequence of linking the laudable goal of epidemiologic data mining with a system of financial reward.

This coding system leads inevitably to distortions in epidemiologic data. Because doctors are required to come up with a diagnostic code on each bill submitted to get paid, they pick the diagnostic code that comes closest to describing the patient's problem while yielding maximum remuneration. The same process plays out when it comes to submitting procedure codes on bills. As a result, the accuracy of the data collected since the advent of compensation coding is suspect.

Coding was one of the earliest manifestations of the cancer consuming the medical profession, but the disease is much more broad based and systemic. The root of the problem is that patients are not payers. Through myriad tax and regulatory policies adopted on the federal and state level, the system rarely sees a direct interaction between a consumer and a provider of a health care good or service. Instead, a third party—either a private insurance company or a government payer, such as Medicare or Medicaid—covers almost all the costs. According to the National Center for Policy Analysis, on average, the consumer pays only 12% of the total health care bill directly out of pocket. There is no incentive, through a market system with transparent prices, for either the provider or the consumer to be cost-effective.

This process will never be arrested without reforms that decrease the role of the third party and enhance the role of the consumer in the payment for health care services. The Affordable Care Act of 2010 does just the opposite.

As the third party payment system led health care costs to escalate, the people footing the bill have attempted to rein in costs with yet more command-and-control solutions. In the late 1980s, private insurance carriers did this through a form of health plan called a health maintenance organization, or HMO. Strict oversight, rationing, and practice protocols were imposed on both physicians and patients. Both groups protested loudly. Eventually, most of these top-down regulations were set aside, and many HMOs were watered down into little more than expensive prepaid health plans.

COMMAND AND CONTROL

As the 1990s gave way to the 21st century, demographic reality caught up with Medicare and Medicaid, the two principal drivers of federal health care spending.

Twenty years after the fall of the Iron Curtain and its central planning, protocols and regimentation were imposed on America's physicians through a centralized bureaucracy. With the use of so-called "evidence-based medicine," algorithms and protocols were based on statistically generalized, rather than individualized, outcomes in large population groups.

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While all physicians appreciate the development of general approaches to the workup and treatment of various illnesses and disorders, we also realize that everyone is an individual—that every protocol or algorithm is based on the average, typical case. We want to be able to use our knowledge, years of experience, and sometimes even our intuition to deal with each patient as a unique person while bearing in mind what the data and research reveal, but under this new regime, the knowledge, experience, and interpretation of research data by a select few—those empaneled with unique authority—is declared the "one best way" that all practitioners must follow.

Being pressured into following a predetermined set of protocols inhibits clinical judgment, especially when it comes to atypical problems. It is easy to standardize treatment protocols, but it is difficult to standardize patients.

What began as guidelines eventually grew into requirements. For hospitals to maintain their Medicare certification, the Centers for Medicare and Medicaid Services began to require their medical staff to follow these protocols or face financial retribution.

As with the coding system, the medical profession's representative organizations acquiesced to these government edicts and eventually became willing enablers.

Patients should worry about doctors trying to make symptoms fit into a standardized clinical model and ignoring the vital nuances of their complaints. Even more, they should be alarmed that the protocols being used do not provide any measurable health benefits. Most were designed and implemented before any objective evidence existed as to their effectiveness. Ironically, the protocols are not "evidence based."

For example, a large Veterans Administration study released in March 2011 showed that Surgical Care Improvement Project protocols led to no improvement in surgical site infection rate. If past is prologue, we should not expect the Surgical Care Improvement Project protocols to be repealed, just "improved"—or expanded, adding to the already existing glut.

These rules are being bred into the system. Young doctors and medical students are being trained to follow protocols. To them, command and control is normal, but to physicians who have lived through the decline of medical culture, this only generates angst.

I fear that teaching young physicians to follow guidelines and practice protocols discourages creative thinking. Less emphasis is placed on understanding the pathogenesis and mechanisms of acute illness, and more is placed on memorizing algorithms. This stifles therapeutic creativity when dealing with complex cases. The bias tends against thinking "outside the box," which is often necessary for patients with clinical dilemmas that do not fit neatly into any box.

Regimentation and standardization in any field stifles creativity and innovation. Medicine is no exception, but the stakes are greater.

I also worry about promoting a culture wherein doctors unquestionably follow the commands of bureaucratic overseers, no longer viewing themselves as autonomous professionals. With the loss of professional independence comes the dissolution of the Hippocratic Ethic. Will the new physician, molded by a culture of regimentation, still place the needs of the patient above the needs of the system?

ELECTRONIC RECORDS AND FINANCIAL BURDENS

The American Reinvestment and Recovery Act of 2009 (the so-called "Stimulus Bill") included a requirement that all physicians and hospitals convert to electronic medical records (EMRs) by 2014 or face Medicare reimbursement penalties.

There has never been a peer-reviewed study clearly demonstrating that requiring all doctors and hospitals to switch to electronic records will decrease error and increase efficiency, but that did not stop Washington policymakers from repeating that claim over and over again in advance of the stimulus.

Some institutions, such as Kaiser Permanente Health Systems, the Mayo Clinic, and the Veterans Administration Hospitals, have seen big benefits after going digital voluntarily, but if the same benefits could reasonably be expected to play out universally, government coercion would not be needed.

Instead, Congress made that business decision on behalf of thousands of doctors and hospitals, which must now spend huge sums on the purchase of EMR systems and take staff off other important jobs to task them with entering thousands of old-style paper medical records into the new database. For a period of weeks or months after the new system is in place, doctors must see fewer patients as they adapt to the demands of the technology.

The persistence of price controls has coincided with a steady ratcheting down of fees for doctors. Meanwhile, Medicare's regulatory burdens on physician practices continue to increase, adding on compliance costs. Medicare continues to demand that specific coded services be redefined and subdivided into ever-increasing levels of complexity. Harsh penalties—even prison—are imposed on providers who accidentally use the wrong level code to bill for a service.

For many physicians in private practice, the EMR requirement is the final straw. Doctors are increasingly selling their practices to hospitals, thus becoming hospital employees. This allows them to offload the high costs of regulatory compliance and converting to EMR.

As doctors become shift workers, they work less intensely and watch the clock much more than private practice. More importantly, shift work interrupts continuity of care. It inhibits the full appreciation and awareness of the evolving dynamics at play in a seriously ill patient. Finally, the doctor-patient relationship is adversely affected as doctors come to increasingly view their patients as the hospitals' patients rather than their own.

In 2011, *The New England Journal of Medicine* reported that fully 50% of the nation's doctors had become employees—of hospitals, corporations, insurance companies, or the government. Just 6 years earlier, in 2005, more than two thirds of doctors were in private practice. As economic pressures on the sustainability of private clinical practice continue to mount, we can expect this trend to continue.

BRAVE NEW WORLD?

For the next 19 years, an average of 10,000 Americans will turn 65 years old every day, increasing the fiscal strain on Medicare. Bureaucrats are trying to deal with this partly by

reinstating an old concept under a new name: Accountable Care Organization, or ACO, which harkens back to the infamous HMO system of the 80s and early 90s.

In a nutshell, hospitals, clinics, and health care providers have been given incentives to organize into teams that will get assigned groups of 5,000 or more Medicare patients. They will be expected to follow practice guidelines and protocols approved by Medicare. If they achieve certain benchmarks established by Medicare with respect to cost, length of hospital stay, readmissions, and other measures, they will get to share a portion of Medicare's savings. If the reverse happens, there will be economic penalties.

Naturally, private insurance companies are following suit with non-Medicare versions of the ACO, intended primarily for new markets created by the Affordable Care Act. In this model, an ACO is given a lump sum or bundled payment by the insurance company. That chunk of money is intended to cover the cost of all the care for a large group of insurance beneficiaries. The private ACOs are expected to follow the same Medicare-approved practice protocols, but all of the financial risks are assumed by the ACOs. If the ACOs keep costs down, the team of providers and hospitals reap the financial reward, surplus from the lump sum payment. If they lose money, the providers and hospitals eat the loss.

In both the Medicare and non-Medicare varieties of the ACO, cost control and compliance with centrally planned practice guidelines are the primary goal.

With increasing numbers of health care providers becoming salaried employees of hospitals, look for even greater bureaucratization and regimentation of the practice of medicine. Hospitals might be able to get ACOs to work better than their ancestor HMOs because hospital administrators will have more control over their medical staff. If doctors do not follow the protocols and guidelines and desired outcomes are not reached, hospitals can replace the "problem" doctors.

Once free to be creative and innovative in their own practices, doctors are becoming more like assembly line workers, constrained by rules and regulations aimed to systemize their craft. It is no surprise that retirement is starting to look more attractive. The advent of the Affordable Care Act of 2010, which put the medical profession's already bad trajectory on steroids, has for many doctors become the straw that broke the camel's back.

A survey of 2,218 physicians, conducted online by the national health care recruiter Jackson Healthcare, found that 34% of physicians plan to leave the field over the next decade. What's more, 16% said they would retire or move to part time in 2012. "Of those physicians who said they plan to retire or leave medicine this year," the study noted, "56% cited economic factors and 51% cited health reform as among the major factors. Of those physicians who said they are strongly considering leaving medicine in 2012, 55% or 97 physicians, were under age 55."

As old-school independent thinking doctors leave, they are replaced by protocol followers. Medicine in just one generation is transforming from a craft to just another rote occupation.

However, what does all this portend for the patient? Because all of us will be patients one day.

Ayn Rand's philosophical novel *Atlas Shrugged* describes a dystopian near-future America. One of its characters is Dr. Thomas Hendricks, a prominent and innovative neurosurgeon who one day just disappears. He could no longer be a part of a medical system that denied him autonomy and dignity. Dr. Hendricks' warning deserves repeating:

"Let them discover the kind of doctors that their system will now produce. Let them discover, in their operating rooms and hospital wards, that it is not safe to place their lives in the hands of a man whose life they have throttled. It is not safe, if he is the sort of man who resents it—and still less safe, if he is the sort who doesn't."

DISCLOSURE

The author declares no conflict of interest. The views expressed are solely those of the author, and do not necessarily represent the views of Valley Surgical Clinics, Ltd., Phoenix, AZ.