By Donald L. McGuirk, MD

A Word from the Medical Directors:

Can Managing Cost Be Part of Managing Care?

Perhaps the older physicians among you will recall the thirteenth and last law proclaimed in the novel, *The House of God*[1]: "The delivery of medical care is to do as much nothing as possible." Written with tongue firmly in cheek in the late 1970s, this novel reminds physicians that a less aggressive approach is sometimes the most reasonable. Perhaps the more sage among you will even be reminded of that part of the Hippocratic Oath that warns against errors of commission. (Recent studies suggest that such errors may be a major problem for American medicine.) Today, the advice proposed by The Thirteenth Law is sometimes greeted with suspicion at best and with accusations of denial of care and threats of lawsuit at worst. What has caused this change of thinking?

In the past ten years, the managed care industry has used "new" methods of physician compensation (capitation rates, "withholds," etc) that require physicians to share economic risk with the institutions that organize and pay for medical services. The managed care industry has also examined the wide variation in clinical approaches to common problems and has sought "best practices" in an attempt to standardize perceived quality and cost-effectiveness.

PMG physicians have had a different experience than our private-practice peers, many of whom have felt a loss of control and frustration with a system that "denies their patients the care they require." These physicians firmly believe—and I concur—that the physician/patient relationship is the cornerstone of medicine as we know it. Many PMG physicians believe that managed care as conducted by our for-profit competitors intrudes on that relationship.

Why has this change occurred? I believe that these issues are only symptoms of the real problem: In most cases, neither participant in the physician/patient relationship is placed at great financial risk by the decisions made. In most cases, the employer is the party responsible for making most payments to a health care insurer, and the insurance company is at risk for any medical costs that exceed the sums paid. Unfortunately, as we know, this arrangement of multiple payors (patient, employer, insurance company, and, yes, in many instances, the government) often leads to cost-shifting.

The real question is thus, "Should the employer and/or health insurance company at financial risk for medical decisions have a right to 'intrude' into the traditionally sacrosanct physician/patient relationship?" I believe the answer should be no, but only if the physician/patient relationship meets certain conditions.

The first of these conditions is that both participants in the physician/patient relationship be willing to base their medical decisions on evidence-based medicine.

Increasingly, as large volumes of medical information become available to patients "at the click of a mouse," patients are discovering what most doctors have known for years: Medical literature can be found that will support almost any approach to treating almost any illness. The physician must know the most appropriate one or two approaches for that patient (not an easy task with today's information explosion). Perhaps an even more difficult task is for the physician to be willing and able to help the patient understand why these evidence-based approaches are the appropriate care for that patient. As requests for medical services increasingly diverge from what would be considered the appropriate "evidence-based" approach, patients should bear an increasing amount of the cost for services they request. Otherwise, Adam Smith's concept of the Invisible Hand (ie, purchaser paying more for an item in short supply) will not come into play, and the affordability of health care will decline. For those who suggest that this approach constitutes "rationing of medical care," I would suggest that many of the 47 million people in America today who cannot afford medical insurance would say that medical care in America is already rationed.

Both the physician and the patient need help to identify evidence-based approaches to diagnosis and treatment. Certainly the state and federal government could have some role in this arena, as have the State of Oregon and the US Centers for Disease Control and Prevention (CDC). More help is required, however—and medical specialty societies could assume a greater role. Traditionally, their role has not been emphasized; instead, the physician/patient relationship has been the cornerstone of health care. This cornerstone now needs help to bear the additional weight of today's medical decisions. I believe that by helping to define evidence-based medical approaches (especially when a better approach is available or

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when several approaches have equal effectiveness but one approach costs substantially less), medical specialty societies could help physician members to regain the control they so desperately seek.

Some contend that the second condition required to forestall giving employees and/or health insurance companies a right to intrude into the physician/patient relationship is that the physician/patient team be willing to make cofiduciary decisions. I strongly recommend the controversial and provocative paper written by Laurence B. McCullough on this issue.[2] By "cofiduciary," McCullough means that ethically clinical decisions must not only be best for the individual patient but must also be population-based. "The regulation of clinical judgment, decision making, and behavior should be developed and implemented on the basis of rigorous scientific evaluation of processes of care, to identify those that can be reliably expected to produce a greater balance of goods over harms for patients as these goods and harms are identified and balanced in a rigorous clinical perspective that will define the medically necessary".[2:94]

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McCullough suggests that without the physician and patient being willing to at least consider their decision in the light of all patients as well as the one patient involved, the financial decisions paid for by others cannot be put into perspective. This idea is indeed controversial. Some will say that this scenario will never take place. Trust and confidence are mandatory for the patient/physician relationship to work. For the participants in this relationship to consider others during deliberations will be a significant challenge.

Without this "reality check," however, some will suggest that the system will eventually collapse under its own economic weight. If these commentators are right, this collapse cannot be allowed to occur; it will be stopped by seizure of the financial controls—if not by employers or the insurance companies, then presumably by the government in some form—and the control desired by physicians and patients will undoubtedly erode. ❖

This editorial reflects the personal opinion of the author, and not necessarily that of PMG of MA or Kaiser Foundation Health Plan.

References
1. Shem S. The House of God: a novel. Chapter III, p. 420 (New York: R. Marek Publishers, 1978).
2. McCullough LB. A basic concept in the clinical ethics of managed care: physicians and institutions as economically disciplined moral co-fiduciaries of populations of patients. J Med Philos 1999;24:77-97.

My Doctor

Never stay in treatment with a doctor who thinks that you can't get better.

Andrew Weil, MD, "Spontaneous Healing"