Who Needs Physicians?

By Jason Campagna, M.D., Ph.D.

Save the leeches and the cups, you may need them. The 15th century is fashionable again. Doctors have become just one participant in the "patient-care team." What if we stop going to work and let the faith healers and the doulas and the technicians and the assistants have at it?
(Courtesy of the National Library of Medicine.)

— Jason Campagna, M.D.

There is a not-so-quiet evolution occurring in medicine. The doctor is slowly, but methodically, being replaced. In an era when politicians promise "more, better, cheaper" health care, the business world, the world of for-profit medicine, is executing its own vision of this promise. With each passing day, more and more hospitals, doctors' offices, imaging centers, and walk-in clinics are being staffed with increasing numbers of non-physicians. The Target Corporation has opened rapid-treatment clinics in its stores, staffed with physician assistants or nurse practitioners. That MRI your mother is scheduled to get next week? From the time of her arrival at the imaging center to the time the scan is read, chances are she won't see a physician. Never mind that the image might even be read halfway around the world in India. Show up at the clinic to get a surgical consultation on your dad's lung cancer, and nonphysicians will perform much of his history, physical examination and preoperative planning. If your dad goes on to be hospitalized for removal of his tumor, then there is a growing chance, already very likely in many states, that his anesthesia provider will be a person who will not have done a residency in anesthesia or even gone to medical school. This transformation is occurring because nonphysicians are replacing physicians. Medical care in America is no longer about patients. It's about consumers and services. In this world, health care is a commodity, bought and sold like stocks on the NASDAQ or NYSE. The key players in this version of medicine are the consumer (formerly the patient) and the provider (formerly your physician). The services "provided" to the "consumer" are what used to be called medicine.

Although we will crow incessantly about how the business moguls and the insurance titans and politicians are responsible for our marginalization, I offer one more pungent truth: Physicians as a group are as much to blame as anyone for the predicament in which we all find ourselves. A perfect illustration of this complicity can be found in a report issued in 2004 by the American Association of Medical Colleges. The AAMC convened deans from some of America's most prestigious medical schools as a working group on the future of medical education. The following is a summary "action item" from their report:

> *Medical schools and residency programs should provide clinical learning experiences of an interdisciplinary nature for the purpose of preparing future physicians to function effectively as members of a* ***care team*** *(bold added for emphasis).*

Taken at face value, it is concerning. When viewed, however, in the context of the current changes occurring in health care—it is nothing less than a surrender, a gross acquiescence on the part of organized medicine.

The "mantra" in the American system of health care delivery (a.k.a. *medicine*) is that of cost savings while simultaneously improving "quality." There is no denying that cost of health care is a major issue for our society. According to the Congressional Budget Office, we spend more than 15 percent of the GDP on this endeavor. The absolute number is not so alarming to policy people; it's the *rate of rise* of this number that tends to get people's attention; and it is rising fast. This statistic has been the driving force behind the massive reorganization from traditional fee-for-service medicine to managed care during the past three decades. Now, in the early years of the 21st century, we have found ourselves standing bleary-eyed in the midst of a Kafkaesque landscape where, just as in the 1970s, those rising costs frighten businesses and also, like then, have politicians clamoring for some way to reduce "spiraling health care costs."

A key argument marshaled in the 1970s was that other countries spent a considerably smaller percentage of their GDP on health care. This argument has been slightly modified in our present debate to include not only our enormous expenditures, but also that we deliver care of lesser quality for all that money. Whether this is true is unclear (for example, how can a system that is partially socialized, like that in the U.S., spend more than systems that are fully socialized, like most of the European Union countries?), but this supposed "truth" is now repeated in the media nearly *ad nauseam* and is used as a bludgeon to cull any opposition to the "improve medical quality" bandwagon. Here again is a quote from the AAMC *Ad Hoc* Dean's report:

> Although it is generally believed that the quality of medical care in the United States exceeds that provided in the rest of the world, there is growing evidence indicating that the care is often less than optimal. The results of a number of well-conducted studies show that doctors fail on occasion to use diagnostic and therapeutic approaches of proven value and to communicate with patients and their families adequately, and do not always recommend health promotion and disease prevention practices of proven benefit. In 2001, the Institute of Medicine called attention to the need to improve the quality of medical care provided in this country.

The ruinous reasoning that follows from this reading results in pundits being able to associate such putative substandard delivery of medical care with the unrelated, often cited but poorly substantiated statistics that the U.S. allegedly has the highest infant mortality rate, and a below-average life expectancy compared to other industrialized nations that spend less on health care.

In sum, the torch for "medical reform" has been lit, and there are strong arguments being marshaled to improve quality and to decrease costs. One thing is abundantly clear: the effort to reform medicine is being co-opted by persons and companies whose primary concern is profit, not people. In an effort to find ways to control rising costs, a culture of "cost-containment" in health care has sprouted, modeling itself on the successful efforts of augmenting efficiency by non-health care sectors. One belief that has been born of these efforts is that—quite simply—physicians are expensive. So, it is reasoned, one way in which to cut costs is to replace physicians with nonphysician labor. This disturbing reasoning is being applied to nursing as well. It is of great concern that these labor shifts are occurring in large part with the cooperation—in some cases, overt goading—of organized medicine.

Medicine "polices" itself through a variety of means. Of increasing importance are "Quality Improvement" or "Quality Assurance" committees. Formal QI in the latter 20th century evolved to include system-based evaluation techniques adapted from non-health care industries. In every JCAHO-certified hospital in the U.S., QI is a mandated activity.

Broadly speaking, there are two types of QI activities. The first is when the QI process seeks to understand how errors occurred and to implement changes such that the risks of similar errors in the future are minimized. A second is when a prospective change in some device or care model is implemented, and the QI folks collect data to determine if the new practice results in a change in "outcome." The goal of these QI activities is to implement a change that ideally saves money and improves outcomes. Andrew Kofke in the Department

of Anesthesiology at the University of Pennsylvania and Michael Rie of the University of Kentucky at Lexington have written on this subject. A recent article cites as examples of this type of QI activity:

- Systematically decreasing laboratory tests and radiographs
- Requiring approval to order expensive drugs
- Decreasing nursing or physician staff

A bloodletting tool. It was once believed that "bleeding" patients could relieve them of their "evil-humors." The practice persisted in the U.S. until the mid-19th century. *Courtesy of the National Library of Medicine.*

So, a hospital decides to decrease the number of lab tests ordered, or changes the number of patients a nurse cares for from three to six, or replaces a physician delivering your anesthetic with a nurse, with the goal of "cost containment" with contemporaneous "improvement in outcomes." These interventions are what scientists, and many ethicists, would call experiments where one variable is changed, and the effect of that change on another variable—in this case, *the outcome*—is measured. Kofke and Rie argue that, at the least, such practices open health care (hospitals, doctors, and nurses) to litigation. More forcefully, they argue that such QI activities are gross ethical violations, "systematic violations of the Nuremburg laws under the guise of healthcare QI activities." They ask, somewhat pointedly, "Who among us would volunteer to be a participant in a research experiment with the outcomes being money saved and death rate?" The scenario is bleak. Medicine is willfully participating in the effort to replace physician services.

The 21st century has brought with it a sense that medicine and medical care have never been better. The media informs us daily of medical, scientific and technological breakthroughs. The medical and scientific communities will in many ways support these grand visions of progress. The capital markets and the National Institutes of Health have wagered enormous sums of money that these visions are more correct than not, and people, for the most part, are enlivened with such omnipresent chatter of progress.

One consequence of this optimism is that people tend to forget what a wonder medicine actually is and the central, indispensable role that physicians continue to play in these advances. People are no more impressed that a surgeon can remove a brain tumor than they are by picking up a cell phone and hearing a dial tone. I would wager that some of them are even more impressed that their cell phones can receive television pictures than they are that another human being can "put them to sleep" for brain surgery and then "wake them up" when it is all over and just send them on their way. Modern medicine ***is*** a wondrous place where technology has enabled patients to expect—in fact, demand—cures, and caring, and procedures and medicines to combat just about every ache, pain or growth. But, as anyone can be reminded whenever an airplane experiences some turbulence or a pilot is forced to make an emergency landing, the safe and routine are anything but. The "impression" of routine belies massive potential for things to go wrong. For this reason, and this reason alone, physicians matter. If only our patients understood this elegant truth.

I would argue that the current medical "superstructure" has been built because of the lure of money and a shortage of leadership by physicians. Along with the rise of the medicine-as-money model and patient-as-consumer nonsense, there have sprung up schools and programs and even correspondence courses that let John or Jane learn how to be a "medical professional" from the comfort of their own home, and of course, earn a great salary to boot.

I fear it is too late for physicians to reclaim the mantle of "physician" instead of "health care professional." I worry that people have no sense of what a long road we have *crawled* along to get to the 21st century where cures and miracles seem an almost daily occurrence. I worry about what would happen if physicians really stopped *caring* and just became opportunists who stopped innovating and instead just showed up and worked: simple labor without regard for what comes next, or what new drugs we need, or what new cures we should have. Maybe the best way to get the general public to think about these things is to remind them what it was like when medicine was little more than prayer and potions and nostrums and, in the end, despair. If the medical superstructure wants to replace physicians and restore the world to pre-20th

century medical science, perhaps everyone should be reminded of just what the 15th century was all about.

Dr. Campagna practiced academic anesthesia on the East Coast prior to settling in Santa Barbara in 2005. Most recently, he has published a review of anesthetic mechanisms of action in the New England Journal of Medicine, *and a historical narrative about the social and religious controversies surrounding the use of anesthetics in the 19th century. Dr. Campagna, being new to the CSA, contributed this article to the* Bulletin *in the hopes of stimulating discussion about the trajectory on which our specialty finds itself and where we may be in the near future if that pathway remains unaltered.*

Greater Anesthesia Service Political Action Committee

Imagine a scenario where the profession is powerless to protect the public from those who endeavor to limit patient access to an anesthesiologist's care. Then envision a world where, without impunity, patient safety can be compromised with cost-cutting measures designed by those who stand to profit most.

CSA legislative advocacy is your voice in Sacramento. We urge you to join your fellow anesthesiologists in supporting the profession by contributing to the CSA Political Action Committee (GASPAC).

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