

1844-1994



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Lancaster City & County Medical Society

# Section 1

## *The History of the Lancaster City & County Medical Society*



LANCASTER, PENNSYLVANIA, 1844

## Chapter 9

# *Lancaster Medicine Editorials*

*The Official Publication of the  
Lancaster City & County Medical Society*

### *No, Virginia, There Is No Santa Claus*

We herewith reply to the following letter received right after the holidays (with due apologies to the New York Sun).

Dear Editor:

My Uncle Sam has been telling me over and over again that if I would join a Health Maintenance Organization (HMO) I would get the best medical care, as much as I want, whenever I want, wherever I want for practically peanuts. I would get most of my care free and the rest some insurance company would pay for, so it wouldn't really cost me anything. Now I am sure my Uncle Sam wants me to have the same kind of medical attention that Senator Kennedy and Senator Javits get for themselves and their families so that's really like Christmas every day.

My own doctor tells me that's a bunch of malarkey, but he's the old fashioned kind who thinks there's no free lunch anymore. He did stay in the room long enough to tell me my Uncle Sam is right and there is still a Santa Claus.

Dear Virginia:

It is unfortunate that Uncle Sam and his bureaucrats believe that if they write something down, that act alone makes it true and real. The best (or worst) examples are statements like the medical industry does not respond to market influences, doctors determine the cost of medical care, doctors run the hospitals, all doctors make a million dollars a year (who do they think they are, ball players?). Or better yet, all doctors are overpaid and should be cut down to size. They still cling tenaciously to the fiction that if a medical care buffet is offered free to everyone, each will take only what he absolutely needs and not more. Along with that is the belief that if hospitals are paid on the basis of their costs their reimbursement eventually becomes zero.

Yes, it is true you can get fine care in an HMO but your Uncle Sam is wrong about the rest of it. You must understand what an HMO is and how it operates. Essentially an HMO is an INSURANCE COMPANY that offers you a medical care package for a fixed monthly or annual fee. THAT'S IT! Properly administered it can provide excellent care usually at a lower cost than is now being paid. How can that be you ask? There are two main ways of reducing the amount of hospitalization and controlling access to specialized care. A phrase that describes this is RATIONING OF MEDICAL CARE. Call it anything you like, that is what it is. When you have a fixed number of dollars coming in, the expenditure of those dollars must be controlled if you want to stay in business.

Now, cutting costs is a great and wonderful thing to do but it has to be done carefully. Take the hospitals, for example. Sure they are expensive and probably over priced. But even after you squeeze out all the water, they still need a number of dollars to operate. If you want that hospital to be waiting, ready and able when you need it, the nourishment must be provided. So reduction can go only so far, and that may be far less then you would hope. Specialist care is a similar situation. It is expensive and most of the HMO's that still survive have learned that they may not allow subscribers to use their own discretion in deciding to go for specialist care or even to choose which specialist to go to. In many HMO's all referrals must go through the primary care physician by phone, letter or visit. You should be getting the picture. An HMO can give you all the medical care you NEED. You cannot get all you want, where you want or when you want. Most people who need medical care want more options, not less. You can't have this in an HMO. Medical care is rationed despite what the government wants you to believe.

The HMO is an alternate method of providing and getting medical care. It provides first dollar coverage but, of course, the annual premium must reflect this expensive feature. It probably is one of the least expensive first dollar coverages because there is no individual billing and payments which are such an horrendous administrative problem. There are alternate forms of insurance which include a deductible up front, and as a result are cheaper. The first dollar costs are covered by savings accounts which can be drawing interest while waiting to be used. Still other methods of payment for care are available which we hope to talk about later.

Yes, Virginia, there is an answer to this problem but the ivory tower, blue sky, wet-behind-the-ears bureaucrats don't have it yet. There is no Santa Claus to pick up the tab.

*Roland A. Loeb, M.D.*  
February 1981

### ***Medicare: Our Very Own Trojan Horse***

Lancastrians have good reasons to be more than passingly interested in the Medicare program (a government plan for the medical care of the elderly). It was enacted into law in 1965 when Dr. James Appel was president of the American Medical Association (AMA); only the second Lancastrian to be so honored. The AMA had led the bitter fight to convince Americans they were being sold a bill of goods. It was thus Jim Appel's task to play the statesman's role and ask all physicians to now do their best to make Medicare work.

The power at that time resided in the Department of Health, Education and Welfare. "Let us provide health care for our elderly," was the plea of Harry Truman and his staffers. When fully implemented the annual cost

would be no more than \$15 billion, they claimed; and no amount of argument that the figures were fudged had any effect. At the time the writer belonged to a dinner society on the order of the "National Press Club" format. My presentation argued that the real cost would be hundreds of billions, the government would take over the practice of medicine and the quality would be irretrievably debased. The vituperative audience response nearly drove me off the platform. I ate no dessert that night!

As Tucson physician Jane Orient, president of the Association of American Physicians and Surgeons, points out, any government run system requires universal, compulsory participation. If all the exits are not sealed off those who will not put up with the constraints of the system will escape. President Johnson understood this and saw to it that all over 65 had their hospital insurance paid by a payroll tax. Only the Part B was allowed to be voluntary.

As soon as Medicare became law demand for services went into the stratosphere. By 1980 Medicare was costing us almost \$70 billion and this year's estimates are for \$179 billion. The government's answer to such runaway costs is price controls. "Usual, Customary and Reasonable" became as well known as "Don't Tread on Me." The trouble was they weren't usual or customary and certainly paying 70% of a median 1970 charge was anything but reasonable!

Any attempt to make the system work was met with further government regulations so complex that it became impossible not to break the law, however inadvertently. Physicians became "providers" and penalties for non-compliance were made so severe and draconian that practicing medicine today puts you at risk of jail or bankruptcy. For this we need 12 years of higher education.

So far our elderly have been pretty well shielded from the effects of price controls. Most of them, I am sure, believe the government is paying their physicians the full fees they read about. They certainly would not walk into the Bon Ton and demand a pair of pants for half price but Medicare can tell the physician he gets only half what the service is worth; take it or leave it.

Of course the younger Americans through their insurance or out of pocket are picking up the unpaid tab. But this cannot go on forever. Eventually, perhaps soon, the system can no longer handle the cost shifting and the Greeks will come out of the horse. Then will come the rationing, based on patient age and other exclusions. The Medicare law states specifically that the government will never interfere with the practice of medicine, but all physicians, and many patients, too, know that actions speak louder than words.

Hillary Clinton's task force was well aware of the dangers of government medicine. No wonder their meetings had to be kept secret!

*Roland A. Loeb, M.D.*

November 1994

## *The Most Dangerous Man*

Although the political problems of health care reform demand our attention, ongoing problems of Medicine are still with us. The care of the dying patient and physician assisted suicide are two of the more immediate. Public opinion polls favor an active role for physicians in the dying process and initiatives such as Washington's Proposition 119 and California's Proposition 161 legalizing such activity failed to pass by a narrow margin only.

An eighteenth century physician humanist, Christoph Hufeland said, "If the physician presumes to take into consideration in his work whether life has value or not, the consequences are boundless, and the physician becomes the most dangerous man in the state." John C. Harvey, M.D. of Georgetown University Medical Center feels two things have kept the euthanasia topic center stage; advanced medical technology inappropriately employed in treating the dying patient and, secondly, people fear the possibility of intractable pain, nausea and vomiting from treatment for cancer and other terminal diseases.

We have had occasion before to point out our attitudes towards mercy killing; our moral and ethical traditions go back first to the Greek philosophy of Hippocrates and Apollo where the physician is urged never to do wrong to a patient nor to give a deadly poison, even if asked. This was later replaced by the Judeo-Christian ethic. Apollo was displaced by God the Creator who gave the physician a warrant to heal.

These philosophies have led to an understanding that the physician does his best for the patient at all times, with the physician determining what is best. Our relationship with the patient is a covenant with rights on the part of the patient and duties on the part of the physician. This covenant is recognized by law. The physician's primary duty is to do no harm, to do good as he sees good, to relieve suffering and to cure disease. When an action is not in the patient's best interest, even though requested by the patient, the physician has no obligation to perform it. The patient's rights include the right to be unharmed by the physician's treatment, to be treated humanely, with dignity. The patient also has the right to refuse treatment.

We do not wish to get into a theological or legal discussion of suicide and mercy killing. Both religion and the law oppose such acts. Of greater importance to the physician, such killings are contrary to medical tradition and morality. The Hippocratic Oath, the code of ethics of the American Medical Association and the American College of Physicians forbids them. The World Health Organization code of ethics forbids them. The physician must not abrogate his duty to heal his patient by killing him!

The argument that killing and letting die by withholding or withdrawing treatment are the same is not true. In the first instance the physician is the killer; in the second, the disease. To kill a patient as an act of "mercy" ignores the ability of aggressive palliation to keep a patient comfortable. Physicians

must not allow themselves to be state sanctioned executioners. Our patients must never be put in the position of wondering if the physician will help or hurt him. That is the real disaster.

*Roland A. Loeb, M.D.*

March 1994

### *The Kevorkian Aberration*

With the Nation's and Medical Profession's eyes fixed on the Clinton Health Care Reform we must be careful to avoid trivializing or ignoring the malevolent implications of the homicides carried out by Dr. Kevorkian. His jailing may give us a short breathing spell but the real question is still unanswered: should physicians allow themselves, voluntarily or involuntarily, to be involved in shortening the life of another human being?

In the 2500 years since the writing of the Hippocratic Oath nothing has improved on the ethical principles expressed in this most hallowed document. It exhorts the physician to live a life of virtue, to do only good and no harm, to respect confidences and to perform no euthanasia or surgery. The virtuous physician was expected to choose the proper path in the face of a particular moral choice. Sadly, we cannot assume such a happy event would occur without great effort.

History shows us that Kevorkian's activities are not unique, peculiar to him. Study of World War II and the Nuremburg trials in 1947 showed that doctors were attracted early on to the German Nazi movement. The Nazi racial policies could never have flourished without the support of the legal, medical, industrial and university communities. Doctors joined the Nazi party in great numbers and embraced the dogma of racial purity.

The German sterilization law was said to have been modeled on the 1920 U.S. sterilization program. In 1939 the Germans started their euthanasia program in which doctors were commissioned to grant mercy deaths to the incurably ill. Supervised by doctors, this was expanded to homosexuals, gypsies, communists, prisoners of war and finally Jews.

Experiments carried out on prisoners of war and concentration camp inmates by doctors and scientists were unmatched in their evil and cruelty. Russian prisoners of war (POWs) were submersed in icy pools to test the effects of hypothermia. Prisoners were infected with typhus to keep a supply of rickettsia for further experiments. The experiments of Josef Mengele on twins and dwarfs were inhuman even by Nazi standards. He would, for example, infect one twin and keep the other for control. When the infected twin died he killed the other to compare the organs. In the concentration camps, doctors were active in selecting those to live to fill the slave labor quotas needed by German industries.

If we are not to repeat this dreadful experience we must study its history.

Of great help is the United States Holocaust Memorial Museum in Washington, D.C. Part of its administrative structure is a Medical Advisory Committee consisting of an interfaith group of biomedical educators, ethicists, medical administrators, foundation executives and others. They plan to study the medical profession's relationship to the German government and its social structure. To explore the frailty of the medical ethic in the face of social pressures.

We have much to ponder. Where does the recent cloning of human embryos fit in? The gradual acceptance of nontreatment of the terminally ill. There is no shortage of ethical problems to consider; the use of gender in the design of certain medical studies, the involvement of physicians in the execution of convicted criminals, the right-to-die posture — which brings us full circle to Dr. Kevorkian. He is no aberration, but an integral part of the fabric of ethics in Medicine.

*Roland A. Loeb, M.D.*

December 1993

### *The Ship Needs A Rudder and A Captain*

In the musical play "Two By Two" Noah refuses to permit his sons to build a rudder for the Ark because God, who micromanaged its construction, did not specifically instruct him to install one. The first storm showed him how wrong he was and the boys were allowed to attach it and save the ship.

Which brings us to the political storm pounding the ears of today's physician. For many years the federal and state health administrators have reduced the power and authority of the physician by calling him a "provider" (with a small p). This writer has in the past frequently deplored the use of this term as well as the term "doctor." This latter is a generic term used by many people from PhDs to cosmetologists. The physician, on the other hand, is specifically a graduate of an allopathic or osteopathic school of medicine with special privileges granted by our fellow citizens.

Hillary Clinton's health planners would like very much to replace expensive physicians with cheaper providers. The non-physician providers are hoping that the federal task force on health care reform will open the gates for their increased role. The American Nurses Association have been especially aggressive in their call for independent practice. The many non-physician groups include nurses, chiropractors, psychologists, social workers, optometrists, nurse midwives, nurse anesthetists and many others. They have formed the Coalition for Quality Care and Competition to advance their cause.

There are about 100,000 advanced practice nurses with incomes ranging from \$42,000 to \$77,500 annually. There are 25,000 physician's assistants whose average income is \$49,000. Optometrists number 26,000 with an average in-

come of \$75,000. Clinical psychologists number 70,000 and their income ranges from \$10,000 to \$282,000. Chiropractors number 46,000 and their average income is \$102,000. Finally there are 77,600 physical therapists with an average income of \$25,000 to \$50,000.

We do not mean to imply that the non-physician providers do not play a useful, even vital, role in dispensing medical care. Many of them want to practice Medicine independently, free of physician supervision. They claim they can be gatekeepers, practice in rural underserved areas and do it better and cheaper than physicians. On close inspection such claims are open to question. Even if these were not turbulent times, the medical ship would need a rudder and a captain to set the course. Only the physician has the broad based, intensive education and training to "handle anything that comes down the road." The "crew" performs a vital and essential service and the physician could not function without it. Under our present society the physician is equally irreplaceable.

*Roland A. Loeb, M.D.*

May 1993

### *Who's In Charge Here?*

There was a great cartoon in the New Yorker Magazine (where else?) showing a frazzled keeper in the monkey house trying to get his cap back from the scampering beasties while an elderly woman was outside the cage pounding her cane on the floor demanding to know "Who's in charge here?"

Health care is certainly on the front burner and President Clinton is to present his plan to Congress September 22. Of course, in keeping with usual government procedure, information was not only leaked to the press, but everyone else. The entire 340 pages were distributed in as many copies as you wished! This allowed everyone but the President to describe the plan and play it to his own tune. Although the task force that devised the plan has been disbanded, Hillary Clinton is very much in the forefront, setting the tone of discussion with her statement that they will listen only to those who approve of the plan; no "naysayers" are invited. Now, there's a Democratic regime's idea of democracy in action!

Americans have good reason to be concerned about who's in charge. The Administration is proposing to tinker with the best medical system in the world, with participants who have many conflicting interests. We expect our elected representatives to reflect our wishes. The scandals of the past few years involving the Congress showed that wish to be a figment of our imaginations. Clearly the staff who write the rules and regulations for the laws that Congress passes are most powerful. We are now spending 14% of our gross national production on health care and related items and the word is out that this figure must be drastically cut. It is generally believed (and not

denied by the Administration) that at least \$100 billion more will come out of the Medicare budget. Some organizations - including the AMA - think the cut will more likely be \$150 billion to \$175 billion. This would be on top of the \$55.8 billion cut from Medicare (a government plan for the medical care of the elderly) in the recently passed budget bill. And this is on top of the \$80 billion cut from Medicare by the Reagan-Bush budgets.

While we may not be sure who is running the financial show, the Executive, Congress, Insurance companies, staffers, pharmaceutical houses or whatever, there is no doubt who is in charge of quality: the physician and his partner, the patient. For the past thirty to forty years events have served to distance the physician from his patient. Insurance companies have been in the forefront of this process. The physician was paid directly by the company because the patient couldn't be trusted to hand over the money. Then the patient was cast as an adversary. A recent insurance advertisement described the patient as "a walking liability suit looking for a victim!"

This process must stop. The physician and his patient must again become associates with the same goal, the well-being of the patient. We and the hospitals and all providers of medical care must vigilantly protect the patient from second class medicine brought on by unwise regulations that will cut costs while blocking access to proper care. While Britain, Germany and Sweden are dismantling their socialized medicine programs and returning to private and fee-for-service medical care, we should be most careful about following a road they have already proved is dead end.

*Roland A. Loeb, M.D.*

October 1993

### *Tort Law: A System Gone Mad*

It is hardly necessary to define tort law as that part of the law relating to an injury or breach of duty. Physicians, industry and even the general public have good reason now to be familiar with the term. When Medicine was the greenest and most golden field for the plaintiff attorney to seek his fortune, it seemed that only the physician was being gored. The plaintiff attorney assured everyone that that was only right and proper; the doctor was making too much money anyhow. Melvin Belli and his ilk pictured themselves to the public as white knights seeking redress for bad results of any kind. No longer was it necessary to prove negligence; maloccurrence of any kind was enough to trigger a suit.

Today, the wild profusion of lawsuits throughout our society has brought into sharp focus the true victims of this litigation; the general public. The lawyers would have you believe that malpractice suits are caused by negligent physicians practicing bad medicine. However, the public and the news media are no longer buying that canard. In the past six months we have wit-

nessed a spate of editorials, cartoons and television programs dealing with malpractice and related problems. Some of these efforts miss the mark but they indicate a growing feeling that all is not as the trial bar would have you believe.

The Law, as developed by plaintiff attorneys, activist judges and juries has wrought many changes. Pertussis vaccines almost left the market. They are available at more than ten times their previous price. Bendectin was forced out of the market even though it was Federal Drug Administration (FDA) approved and Merrill Dow had lost no cases in court. After the Dalkon Shield problems, Searl's Cu7 was attacked and is being withdrawn because the income is less than the cost of defending the suits. This leaves only one intrauterine device for contraception (IUD) on the market.

Union Carbide's problems in India are a bonanza. The legal profession's behavior in this instance is too well known to repeat here. The traditional rules of personal responsibility and the law of contributory negligence are no longer observed and, in effect, the common law has been revoked. It is no longer true that if you use state of the art knowledge and due diligence, you have no liability. In Maryland, a gun manufacturer was held liable because one of its guns was used to shoot the plaintiff. In the midst of the nation's grief over the deaths of the seven astronauts, lawyers were informing the news media how the families could sue the government.

The lawyer representing astronaut Grissom's widow told reporters how she lost millions of dollars by waiting so long before suing the National Aeronautic and Space Agency (NASA) for her husband's death.

To return to the field of Medicine; we believe the public is only now beginning to get a glimpse of the real cost of the malpractice fiasco. The premiums paid for malpractice insurance are the smallest part. The overutilization of tests and procedures in defensive medicine are estimated to cost several times that of insurance premiums. Added to that are the real dangers that any invasive procedure carries, plus the significant number of false results produced by those tests, and as a result, requiring further tests that may even lead to patient injury.

We are not done. Certain worthwhile but high risk procedures; neurosurgical, orthopedic and obstetric, are no longer being done in places like New York and Massachusetts. Patients who might be treated in community hospitals are being transferred to medical centers which can better take the risks of lawsuits. Some insurance companies will not offer coverage at any price. Midwifery has been a notable victim of such non-availability. Lloyds has withdrawn from the U.S. market.

Further compounding the problem are the size of the insurance policies and the Catastrophic Loss or CAT funds. Given the unlimited awards by courts and juries, the multimillion dollar policies and CAT funds are designed to feed on avarice and greed; a virtual lottery with little to be lost and a for-

tune to gain. Rand Corporation Institute for Civil Justice has estimated that in a successful contingency-fee case, two-thirds of the award goes to lawyers and one-third to the plaintiffs. Class action suits, such as the Union Carbide, give pennies to the injured and millions to the lawyers.

We still have a long way to go, but it is clear that tort law must be changed. The excesses of the present situation are waking our patients and the public to what is happening. No one will deny that a patient injured by negligence is entitled to redress. Nor will any deny that the practitioner who is incompetent or negligent should be denied further license. But this is a far cry from the present chaos. To protect our patients we must help correct these problems. This means becoming informed, keeping in touch with your medical societies and conferring with your legislators. If we wish to practice medicine as we think it should be practiced, we must do more than watch events. We must be an active part of those events.

*Roland A. Loeb, M.D.*

March 1986

### *Guess Who's Gonna Be Dessert?*

The medical scene has all the aspects of a jungle. The Washington tribes, joined by the labor and industry shamans as well as the American Association of Retired Persons (AARP) are all dancing around the big iron pot, keeping perfect cost-containment rhythm. As the legislative drums bang louder, physicians may be forgiven if they have an uncomfortable feeling that it is they who will end up in the stew. However, while the physician may get a bit singed around the edges, it will be the unhappy patient who gets boiled and eaten.

Which presents us with a bit of a problem. If we alone were at risk, simple self-preservation would indicate retirement or withdrawal from the field to enter more lucrative and less dangerous pursuits. As the advocate of the patient and protector of his health, such an easy solution must be gainsaid. If we don't hang in there and do what we can to maintain a high quality of care, it is becoming ever more clear that no one else will.

We need not take too much space to recap what has occurred so far. The Diagnostic Related Groups (DRGs) have cut hospital revenues even at this early point; and worse is yet to come as they grow to 100% of Medicare payments. Studies are under way to extend the DRG system to physician payments and to combine hospital and physician payments into one sum. Congress has frozen Medicare payments for fifteen months and is talking about extending the time for at least an additional year. It has imposed sanctions upon physicians who do not accept assignment all the time and it has forced some groups such as independent laboratories to accept assignment whether they want to or not.

While organized labor voices its suspicions that the medical profession is ripping everyone off, the companies are forming coalitions and reducing their medical costs by increasing, at first, their non-union employee co-payments, restricting their access to certain physicians and hospitals, controlling access to care through review by nurse coordinators, mandating second opinions in surgery and imposing penalties on the employee who does not conform. As their union contracts terminate, they will try to secure the same terms for those medical benefit packages.

Payment for serving Medicare and Medicaid patients has steadily deteriorated. The number of participating physicians has dropped three percentage points, from 85% to 82%, in the past five years. While this was most noticeable in the field of pediatrics, the pattern is generally the same in primary care and the other specialities.

The new Congress is concerned with budget deficits and it is expected that Medicare and Social Security will come under the ax. Hospital payments would be cut and premiums for Medicare Part B would be increased. Indirect costs for medical education would be cut in half, from 2 billion to 1 billion; threatening further the stability of our teaching hospitals.

There is no way these reduced funds can produce anything but reduced services. It is an economic axiom that under the best conditions you can get what you pay for. You may get less, but you never, ever get more. Sadder yet is the fact that these measures will not reduce the debt to any significant degree nor "save" Medicare.

We must awaken our patient to the financial realities and the danger of damage these measures pose. Patients are our natural allies and the immediate beneficiaries of quality Medicare. Each day we speak face to face with millions of them. Once they get the message, our legislators will hear from them.

We will have to give office time for listening as well as talking. We have fallen very low in the public esteem and it will take great effort to regain what we used to have. But we must not fail in this. To do so condemns the finest medical system in the world to move in the direction of the feldsher and the barefoot doctor. And the patient, whom we are here to protect, will get hurt.

*Roland A. Loeb, M.D.*

February 1985

### *The View Ahead*

Among those viewing today's medical scene with alarm are our *New England Journal of Medicine* Editor, Arnold Relman and Medical Economist, Eli Ginzberg. The latter is particularly concerned over what he calls the "monetarization of medical care" which dominates present thinking. He de-

finer monetarization as the rapid penetration of "money economy" into all facets of the health care system. As evidence there are the financial growth of academic health centers, the shift from voluntary to paid physicians in large teaching hospitals, salary increases to house staff, the great decline in the role of philanthropy in meeting the needs of non-profit hospitals, the inroads of for-profit hospital corporations, the almost complete elimination of charity care by physicians and hospitals after the introduction of Medicare and Medicaid.

The process can be said to have started with a perfectly legitimate concern about health care for the indigent and the unemployed; about the time of World War II. The development of Blue Cross and Blue Shield was a step in that direction and a large part was played by the medical profession. An unexpected consequence of the Blues' paying hospitals and physicians directly was to insulate the patient from knowing the value and cost of the medical care received. This situation is one of our major problems today.

The federal government was also anxious to get into the act. The Department of Health, Education & Welfare (predecessor of the Health and Human Services) looked enviously at Britain's dole system and National Health Service. A Washington directed campaign against means tests, the shame of accepting and giving charity and the wonders of federally controlled medical care pulled out all stops. The American Medical Association and any others who voiced doubts about the costs and desirability of such a program were subjected to vituperative attacks in press and radio. The Hill-Burton Act in 1946 allowed hospitals to expand their physical plants and in 1965 Medicare and Medicaid laws were passed. Their reimbursements based on stated costs were not long in heading up into the stratosphere. Congress estimated that by 1970 the total cost of Medicare would be \$3.1 billion. It was, instead, \$5.8 billion. As everyone knows, since then it has been steadily upward.

There are other reasons for the \$322 billion spent for health care in 1982. The medical care provided today is not the same product available for sale in 1965. It is far better and costlier. The medical school graduate spends a fortune getting his medical training, enters practice with a backbreaking debt as well as a family and expects to earn a good income at once. Nor must we forget that defensive medicine is expensive and every dollar spent on lawyers, in the courts and in awards, comes out of the patients' and taxpayers' pockets. And then, because of the quality of medical care, more of us are living longer, insurance beneficiaries are making more medical visits, fewer infants are dying, very few people get polio, no one gets smallpox, and so on. None of these considerations have been factored into the estimates or controls.

Now Congress would call a halt to their costs for Medicare and Medicaid. Industry has figured the costs of their giveaway health fringe benefits and are equally determined not to lose the benefits they got at the bargaining

table. The private insurers don't want to get caught in the storm so they are going to cut back also. The HMO, the Preferred Provider Organization (PPO), the Independent Provider Association (IPA), the DRGs are all designed to reduce costs.

Such constant and growing emphasis on expenses and cost controls have aggravated the conflict between medical ethics and quality care and the goals of money making and money saving. Those who control the purse strings view the practice of medicine as just another business like selling cars or pizza. There is little concern for the profession of medicine as a calling. Today one does not even hear lip service to the quality of medical care; all we hear is the cost of this or that procedure, the reduction and rationing of care, threats about retroactive denial, loss of hospital jobs and cut throat competition. The advent of advanced technology such as nuclear magnetic resonance imaging may please its inventor but it causes stark terror in Congress.

Thoughtful observers of the medical scene are deeply disturbed by these prospective changes. The dollar, the regulations, the documentation will become the goals of medical care. The patient will become a pawn in this warfare. The principle of the one to one physician-patient relationship is giving way to the "team," the all out effort to give the patient the best care now defers to "cost-effectiveness." Is this what our patients really want? I doubt it.

Can we reverse this rush to total government control? Only the naive think we can go back to the way things were or that considerations of money are not important. Nevertheless an attempt should be made to return the patient to a position controlling his own destiny. One suggestion has been to require the third party payers to reimburse patients directly and the patient would then arrange the physician's fee in the traditional way. It might not work but is certainly worth a try.

*Roland A. Loeb, M.D.*

June 1984

### *Is It Really Spinach?*

Elsewhere in this issue of Lancaster Medicine is a description of the DRG system of prospective payment to be instituted in our Lancaster County Hospitals this coming July. Some weeks ago we attended with 50 other physicians and hospital administrators a televised seminar on the subject. This three hour session was jointly sponsored by the American Hospital Association and the American Medical Association. As the panel of experts tried to convince the audience that this new program was the one that would control medical costs and not adversely affect the quality of care, there came to mind a Carl Rose cartoon in the New Yorker many years ago. The mother is saying to her child, "It's broccoli, dear." The youngster replies, "I say it's spinach

and I say the hell with it."

Our problem is not that simple. The DRGs are the law and we physicians and the hospitals must try to make it work. Nor is a successful outcome at all assured. The system is launched nationwide, untried. The DRG effort in New Jersey differs significantly from the federal plan and even after four years physicians there are still in the dark about how it operates. The TV panel was unanimous that medical staffs and hospital administrators must change their present adversarial positions and unite to address the common problem; but there is still not a single physician on the governing board of the Summit, N.J. hospital used as the DRG model.

The key variables in the medical care equation are the quality of care and the accountability of the physician to the patient for the total package. While certain aspects of care may be delegated to aides and paramedical personnel, the ultimate responsibility lies with the physician.

Prior to the advent of the DRGs the common purpose of the physician and the hospital; the care of patients, was carried out with reasonable facility. The physician could avail himself of all the medical and hospital resources with little or no restriction and the hospital could expect to collect all its costs from government or private insurers. You don't need a savant to tell you this will now change. The Department of Health and Human Services (HHS) has made it very clear that it intends to reduce the amount of government spending for medical care. Quality care will be "redefined" from the "most and best care available" to "necessary and cost efficient." All expect the private insurers to follow the same course, if only to avoid cost shifting. The hospital administrator's bottom line must become a financial one and the department or physician whose activities show up red on the books gets clobbered.

While we're on that subject you should know there will probably be a new kid on the block—the DRG Coordinator. His function will be to tie in the medical staff, service departments and medical records so that the hospital receives the maximum income from the system. He will identify those hospital areas that are not operating efficiently and recommend necessary changes. The medical records department will become a major force through its chart and DRG reporting functions. In such a climate we will expect to see increased Medicare admissions of very sick patients, a high intensity of treatment, reduced hospital stay, reduced laboratory, X-ray and other ancillary services. Sensitivity to risk management will increase along with the high levels of stress.

Maintenance of high quality medical care under these circumstances could be a chancy thing and will require from the physician careful planning and unremitting vigilance. The pressures on the attendings from staff, colleagues and administration will be significant. The patient will have to understand the new system and realize that his doctor is no longer the only one calling the shots. As the patient's advocate it remains our responsibility to do this

educating. We will have to explain to the Medicare patient and family the differences between what they would like to have and what is actually needed compared with what the government and hospital rules will allow.

The patients and taxpayers who elect our government and really pay the costs of medical care will also call the tune. Only if they are informed can their choice be a proper one. To make this system function the physician must not only work closely with his hospital administration, he must develop a new level of partnership and cooperation with his patient. In this way we will maintain that quality of medical care that is, by all standards, the best ever.

*Roland A. Loeb, M.D.*

March 1984

### ***Whoa Trigger! Hold Up Thar!***

We recognize how futile and self defeating it is to resist changes that must come in the way we practice medicine. They are necessary and natural phenomena of all living entities; the normal response to internal or external stimuli. DRGs, HMOs and PPOs are simply the latest such provocateurs. Equally foolish is the other end of the spectrum, reacting in panic to what is perceived to be a threatening situation. By now all of us have heard the implied threat that if we don't act immediately and accept Proposition A, Proposition B, or What Have You; someone else will grab our "market share" and we will be left to starve alone out in the cold. It just isn't going to happen. Common sense tells us that you don't change the habits and wishes of 350,000 Lancaster Countians in a few days or weeks. There will be adequate time to study and assess the various proposals and give a thoughtful response.

It is hard to know where you are and where you are going unless you know where you've been. So let's review a bit of history. In a colossal misjudgment of the market place, Congress gave us Medicare and the Hill-Burton Act. The latter allowed unlimited expansion of the hospitals and Medicare's cost-based reimbursement paid all the expenses without limit. If there are still some economists who think the medical industry does not respond to the market place, the Medicare experience should have been iconoclastic. The medical industry responded fully, exuberantly, and medical costs soared into the stratosphere. After almost thirty years, Congress realized what they had done and the DRG plan is their hope to set an upper limit on costs.

This really hit the dominoes with a thud. Hospitals, suddenly holding a lot of uncovered expenses, must either cut back or shift them to other patients. "Not to us." say Blue Cross and other insurers; announcing DRG plans of their own. Nor was industry caught asleep. Three of the larger ones in Lancaster County have already self-insured and instituted cost controls. The medical staff was also affected. Come this July 1 the physician who gener-

ated a lot of X-ray and laboratory studies so dear to the accountant's heart, will be stripped of his good conduct medal, his category reduced to D and driven into the hot desert.

Which brings us to the physician, now known generically by the unsavory term "provider." The HMO and the PPO are devices whose essential function is to reduce the costs of medical care by reducing its availability, namely rationing. This is done by limiting access to hospitals, to the emergency rooms and to specialists. The only "insured" entry into the medical system is through the primary care physician. By putting this physician at financial risk, the HMO exerts pressure on him to ration his study of the patient's problems and reduce the cost of his services. Every country that has socialized medicine has had to restrict the amount of medical care in some way; whether it be two-year waiting periods for elective surgery, no resuscitative measures above a certain age and other restrictive regulations. It should be no surprise that our country is headed in that direction.

If you have survived this historical digression, let's return to the main point; careful study of HMO or PPO proposals and avoidance of precipitous actions. Contrary to what Medicare and HMOs would have you believe, their goals and ours are not the same. Their one criterion of success is the reduction of the cost of medical care. We carry a broader and heavier responsibility.

Congress has decreed that the available money and, therefore, the amount of available medical care will be reduced. The era of "Give me the best and all you've got, Doc. My insurance will pay" is over. This is a decision of society and the physician can operate within the system. However, he still has the responsibility to see to it that the care that is provided is of the highest quality.

This is not a new task for the physician. What is new is that after more than twenty years of profligate and uncontrolled spending a lid is being clamped on the cookie jar. Pressure to cut corners and reduce quality care will be exerted and must be resisted. The patient whose welfare is the real bottom line must be made a partner of the physician. The situation, so confusing and chaotic to us, must be equally so to the patient and we must accept the responsibility of informing him. The real costs of quality care versus costs and the rationing of care must be clarified for them.

These are the fundamental problems and issues we face. They will not be solved by knee-jerk, off-the cuff decisions. They will be solved by careful reflection and measured response. Our patients, the medical profession and we deserve our best shot.

*Roland A. Loeb, M.D.*

February 1984

## *The Tumbrels Are Coming*

We don't want to carry this analogy with malpractice too far but it is understandable if the physician sometimes feels his patient may turn into a French Revolutionary with his own hired Robes Pierre. He then pictures this pair sending him riding on a one way trip to the guillotine.

While the head chopping bit may be fantasy, the increasing malpractice litigation is painfully real. So is the back breaking financial burden that juries place on the system; the system paid for, of course, by the patient and taxpayer. We have all been informed by now that required coverage carried by physicians has been increased from \$150,000 to \$200,000. In addition, the surcharge we pay to the Catastrophic Loss Fund goes up 52% after January 1, 1984. You will recall this fund was established under Act 111 to pay awards in excess of the malpractice limits. In 1977, the fund paid out \$2.5 million; in 1981 it paid out \$19.5 million; \$38.1 million in 1982 and by the end of 1983 it will have paid out \$54.2 million.

The movement of ever upward is accelerating, if anything. In 1976, there were in the entire U.S. four awards that exceeded \$1 million. In 1981 the number rose to 45. Recently in Stanford, California, an infant that became spastic and quadriplegic after respiratory failure was awarded annual payments that could exceed \$120 million if he lives to age 78.

In early December, the Lancaster City & County Medical Society continued its efforts to address the malpractice problems by holding a joint meeting with the Lancaster Bar Association and the Lancaster Osteopathic Medical Society. More than 125 physicians and attorneys listened to a panel of legal and medical experts, asked questions and, in the process, got to know each other a little better. It is not often that physicians and attorneys can speak to each other without the stress of illness or litigation and the experience was a valuable one.

Christopher Mattson, local defense counsel, opened the presentation by laying to rest two myths: that malpractice is due to incompetence. Malpractice is "the failure to do what is reasonable." The second myth is that malpractice is a plot between opposing lawyers. He thought that patients sue doctors for three reasons: there was a result unexpected by the patient, the patient believes the medical professionals were at fault and the patient feels he has no recourse but to go to court. This theme was enlarged upon by the next panelist, David Schragar, President of the American Trial Lawyers' Association and well known Philadelphia plaintiff attorney.

Mr. Schragar pointed out that most patients are very vulnerable in front of a physician; a great deal of trust is reposed in the physician and the patient expects a similar response from the physician. Further, the modern patient is a more sophisticated person than his parents and grandparents were. His reading, watching and listening puts him very much in the mainstream of medicine and he expects his doctor to be even more advanced and to share

his knowledge and view him as a partner in the management of the patient's illness. If the patient perceives that the relationship has broken down, trouble lies ahead.

Mr. Schragger stated the great majority of malpractice suits that are filed are without merit. Where we make a mistake, he said, is paying too much attention to the cases with merit. They should be settled as quickly and as fairly as possible. Where we should be putting the greatest energy is in trying to learn why a suit that has no merit was filed at all. Therein would be the answers to much of the malpractice problem.

We happen to think this is good advice. Certainly the various measures tried so far have not worked. Act 111 has been a disaster. Throwing great gobs of money into insurance and CAT funds has only made the end of the rainbow more attractive and made the lawyers even more anxious to try for the jackpot. We don't think anyone is still naive enough to think he can practice as he damn pleases. We feel control of the malpractice problems lies within ourselves. The principles are simple; a friendly patient won't sue you, a satisfied patient won't sue. A patient who feels you have dealt honestly with him and his family is not about to sue.

To arrive at this happy state we must get closer to our patients. We have permitted all sorts of third parties to plant themselves between us and our patients. To help us practice, the government, insurance companies and veritable armies of paramedical personnel have moved in. Today there is such a mob in the medical scene it is no wonder the bewildered patient doesn't know who his physician is! Granted that modern technology requires use of various skills. This is no reason to give up your responsibility as the "captain of the ship."

When a patient asks a physician for medical care it is because he wants a physician to attend him, not some other type of practitioner. If we accept him as a patient we have a duty to give our best and closest attention. When this is not done, the patient feels neglected and betrayed. No matter how technically excellent the care is, the patient is unhappy.

Control of malpractice suits must start at the receptionist's desk and telephone. The office staff are considered a reflection of the physician's attitudes and the physician must make sure that this is indeed the case. The physician must then discipline himself to back up his staff in carrying out his wishes; and to do whatever it takes to instill in the patient that he and his problems are important to the physician's personal life.

*Roland A. Loeb, M.D.*

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