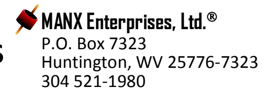

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INTEGRITY IN MEDICINE TODAY
AN EXAMINATION OF THE HISTORICAL EVENTS AND PROCESSES
A KNOWLEDGE BRIEF
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NOTE: This letter was originally written as a sounding board submission to the New England Journal of Medicine which was rejected. I have re-edited the text to update it for publication by **MANX** Enterprises, Ltd.®

SITUATION

To the Editor;

My father, Dr. Milton Gusack of Chevy Chase Maryland [now deceased], sent me a copy of the New England Journal of Medicine 6 June 1997 editorial[1]. He was a retired family doctor who won the admiration and respect of patients and physicians alike through his practice of medicine. His mission, as he saw it, was service to the patient and support to his colleagues. I seriously doubt that someone of his caliber and commitment could have remained in practice today. Medicine has become a business trade where, in return for subsidized financial benefits, many physicians have let their authority slip into the hands of a small number of government bureaucrats and efficiency-oriented CEOs. Few of those people have ever set foot in the medical institutions they regulate, buy, consolidate, or trade like monopoly pieces. This has forced many honest, hard-working physicians to leave the profession early because of the adverse effect this has had on their practice of medicine. This is a serious problem.

That is why I applauded the integrity of the NEJM editorial staff in 1997 for having the fortitude and forthrightness to publish the June editorial. The key point made by that editorial was that physicians may be inclined to make clinical decisions based on either reducing expenses or increasing utilization to maximize personal financial gain. This is a serious charge. If widespread, this behavior needed to be corrected then and certainly needs to be corrected now to preserve what is best about health-care: human compassion combined with rational thought.

The only objection I have to that editorial is that the point made has been misinterpreted by many as the problem. That is, that doctors are solely responsible for all that is wrong with medicine. In fact, the loss of integrity referred to in the editorial is only part of the behavioral response of physicians, patients, businesses, and academic institutions to powerful underlying forces the causes of which are either not well understood or are ignored. Our society is trying to control physician behavior, either through central planning at the national level, or by allowing business administrators to control costs without regard to the quality of patient care. The result? Clinical and administrative decisions made then and today work against maintaining safe, high-quality, useful health-care while simultaneously reducing the capital base and decimating the teams of highly trained and motivated professionals needed to support this mission. And this has led to a disastrous loss of empathy, caring, and rational thought necessary for maintaining a truly successful health-care system.

PROBLEM

Present legislative, bureaucratic, or business-oriented solutions cannot work to:

RISK: Maximize patient safety
QUALITY: Minimize patient pain and suffering
UTILITY: Maximize efficacy and efficiency of patient care

Why? Because the real causes remain unrecognized. And, they won't be recognized until the historic events and processes that have led to our present situation have been thoroughly and dispassionately investigated by our profession. Only then can we in the healthcare field formulate a comprehensive strategy of reform. Let me be even more clear. I want to emphasize that we, as physicians, must act in an intellectually honest and forthright manner to fix our own house, because the people we have let in to do the job for us are destroying it.

HISTORICAL BACKGROUND TO THE PRESENT STATE OF HEALTH-CARE

Over the last eighty years the successful introduction of new medical knowledge and technology has been accelerating. The application of this scientific knowledge and technology to the practice of medicine has resulted in success beyond all expectations. Today, we have the capability to treat and even cure numerous formerly deadly or debilitating diseases. Although we should all be very proud of this success, we should not allow it to cloud our judgment. For, as we achieve technical capabilities which would be considered miraculous just eighty years ago, the system built up that produced these successes seems to be collapsing before our eyes. This has occurred because each success creates its own set of new conditions which, in turn, impose new problems. Defining these new conditions and problems will allow us to start the process of redeeming profession.

SUCCESS LEADS TO A REORGANIZATION OF THE HEALTH CARE SYSTEM AND CREATES UNREALISTIC EXPECTATIONS

The initial successes in modern medicine have had a major impact on the way health care is viewed socially and delivered economically. Success led to public awareness of the technical capabilities of modern medicine causing both patient and physician demand for this technology to accelerate. In response, hospitals have grown large and complex to house expensive intricate machines, execute complicated procedures, and administer highly trained professional teams necessary to achieve this success. In addition, the early successes have led physicians to believe that they can intervene in every case to make the patient "better". This has oversold the efficacy of medical technology and has given rise to unrealistic expectations by patients for a perfect outcome from an administrative technocracy better suited to managing physical resources than to reduce human suffering.

LONGEVITY AND UNTREATABLE DISEASES EFFECT RESOURCE UTILIZATION

The elimination of most acute causes for morbidity and mortality has left us numerous poorly understood, chronic diseases which cannot be treated acutely but must be managed over long periods of time. Concurrently, our society has increased the length of life through effective civil engineering and massive public health projects such as vaccinations and water treatment. The number of people who will survive to old age and, therefore, suffer from chronic, debilitating diseases is exploding. The cost of managing these diseases in a longer-lived population is more expensive than the cost of treating acute, self-limited diseases requiring more not less care, empathy, and rational thought from a system organized to administer technology rather than seeing to the patient's wellbeing.

RESOURCE SUBSIDIZATION EFFECTS HUMAN BEHAVIOR

Technological success has generated increasing societal demands for access to optimal health-care. This has led to federal subsides such as Medicare and Medicaid along with the provision of health insurance coverage by many private businesses. In turn, subsidization has brought with it a complex bureaucracy which requires health-care institutions and physicians to spend more time on billing strategies and less time on patient care in order to obtain and hold onto new financial resources. In addition, subsidization plus technical success has reduced an individual's personal responsibility for their health and has promoted high risk/high cost behavior that compounds the problem. Subsidization has also reduced the incentive for both physicians and patients to limit use of medical resources while, at the same time, attracting people motivated by the prospect of handsome profits through "working the system".

In parallel to this trend is the explosion in federal subsidization of medical research in academic institutions where reaching for every grant dollar that can be gotten subordinates teaching and service to a secondary role. Furthermore,

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the attraction of profits from subsidized research via alliances with commercial establishments has led to a deeper corruption. An intellectual corruption that silences all critical thought regarding any pursuit that may turn a profit or advance the reputation of the institution and its researchers. This has shifted the focus of medical education and training towards technical matters and away from effective patient care. As more and more academic doctors are pushed towards publish or perish, the medical student is left further and further in the background with no beacon of ethical and intellectual leadership to follow.

THE INFORMATION EXPLOSION EFFECTS RESOURCE UTILIZATION

As intimated above, the combination of technological success, growth in demand, and increased subsidization has also led to a rapid expansion in research and development in the private sector. Many of the resulting products and services are remarkable and of great value to our patients. However, many are not, yet are heavily marketed by for-profit industries which seek to optimize stock holder equity, not patient care. This has produced an avalanche of poorly worked out concepts and less well understood information, knowledge, drugs, procedures, and medical instruments amplifying confusion and complexity in medical practice.

The information explosion has been further magnified by the sheer quantity of data generated each time a patient is seen. The data is poorly characterized regarding terminology and poorly organized in terms of storage and presentation in electronic health records which merely recapitulate archaic patient charts. This requires the physician to spend more time entering data and looking for a result than interpreting it. The subsequent "noise" has buried the signal of "good medicine" and has created additional forces that misdirect resource utilization, decreases the quality of care and puts the patient at an increased risk for an adverse outcome. Worse, this disorganized and miscategorized patient data is avidly mined leading to corrupted epidemiological information that misleads our profession as to the veracity of our diagnoses as well as the efficacy of our therapeutic efforts.

THE INFORMATION EXPLOSION IN MEDICAL EDUCATION SOWS THE SEEDS OF MAL-INTENT

The expanding torrent of changing and often conflicting medical information has placed further strain on our educational institutions. In only four years they are expected to convey an enormous amount of unconfirmed and poorly integrated "factual" information to the medical student. Memorization trumps critical thought as little time is left to show students how to evaluate information and apply it in a rational way to investigate and solve medical problems. Even less time is spent teaching students how to manage and evaluate the large amount of clinical data produced during the work up amplifying the adverse effect present eHRs have on patient care. More importantly, minimal effort is made to emphasize a caring approach to the patient. This is made worse due to the tendency of medical school professors to focus on publishing and keeping large prestigious research grants to avoid losing their jobs. All of this instills the seeds of disillusionment and cynicism in both professors and students. In the end, our medical schools' graduate physicians filled with depreciating 'factual' information, lagging commitment, and little in the way of critical problem-solving faculties.

POST GRADUATE TRAINING REINFORCES THE GROWTH OF MAL-INTENT

Even worse is the experience following the formal academic period. Graduates are suddenly considered physicians. They are assigned positions of responsibility and authority over the patient before they are ready. This initiation is carried out under the most inappropriate working conditions including sleep deprivation, poorly organized support services, hospitals built from designs meant for the last century, lack of adequate supervision, and abuse by some staff physicians who are supposed to be mentors and role models. The heavy hand of federal regulations and institutional fear of malpractice law suits simultaneously bars fledgling physicians from gaining adequate experience in critical areas of diagnosis and therapy. On the other hand, the patient, who are now more likely to suffer from chronic, debilitating diseases, requires a physician-in-training who is patient, shows empathy, and exhibits consummate problem-solving skills, not to mention expertise in managing and interpreting large amounts of technical data. How

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can we expect these graduates to mature into competent, caring physicians with sterling intent and superior judgment under such conditions?

THE COST OF LONG-TERM SELF-DENIAL DISTORTS PROFESSIONAL INTENT

Young physicians face unique financial demands which can lead to adverse behavior. Up to sixteen years can elapse from high school graduation to private practice. Large debts may be incurred during a time when medical students and physicians-in-training are expected to live frugally, study hard, and work long, grueling hours. Add the huge monetary demands of establishing and maintaining a private medical practice with staff, space, furniture, equipment, and malpractice insurance. This is not compatible with supporting a comfortable life-style which we have all come to expect from all that hard work and self-denial. Then, to maintain this practice, physicians must see more patients and simultaneously do more billable procedures forcing them to spend less time with each one. There is a subsequent reduction in both the perceived and the actual quality of care delivered while increasing the potential for error…and a law suit. Primed by their educational and training experiences, and encouraged by subsidized insurance payments, physicians may also be inclined toward making medical decisions which unnecessarily increases reimbursement through inappropriate care. Or, faced with a bonus in the capitated managed-care system, toward making medical decisions which withholds appropriate care.

THE RESULT: INCREASED RISK, LOWER QUALITY, AND RISING COSTS

The above conditions have created an economic bubble where increasing sums of private and public money are spent on applying high technology to chronic, complex diseases, creating a large, misdirected technocracy administrated by a generation of physicians and managers who are ill-equipped to understand the system. Even for those who are better equipped, the speed of growth, degree of change, and level of complexity have made it difficult to appropriately and efficiently direct available resources to the provision of safe, high-quality, and effective patient care. The result: a cycle of rising expectations, rapid expansion, misuse of resources, overwhelming complexity, loss of confidence, ballooning liability compounded by cost containment efforts, and imposition of government regulations. A nation-wide consolidation has ensued, managed primarily through business acquisitions meant to maximize profit margins and control overhead through a reduction in the quality and quantity of capital and personnel resources.

CONCLUSION

Patients are now exposed to a much higher risk for being harmed, receive lower quality of care, and pay a higher price relative to what would be expected given our technological capabilities and the investments made by society over the last 80 years. Our present predicament is as much a result of our successes as of our failures. If traditional medicine is to survive the resulting avalanche of technical, social, and political changes, then we, as physicians, must take self-reformative action as ethical and intellectual leaders. If we don't, then, we will soon be reduced to mere technicians, and the control of patient care will pass entirely from our hands ending a golden age.

REFERENCES

1. Kassierer, J. Editorial: Our Endangered Integrity -- It Can Only Get Worse. N Engl J Med 1997; 336:1666-7.

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