EDITORIAL

THE WHOLE TRUTH

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"I swear that the evidence I shall give will be the truth, the whole truth, and nothing but the truth. So help me God."

—Courtroom Oath

The current promoters of free-market economics have stood upside down the ideals of those of us who believe in patient-centered healthcare. We are now looking back at the dire predictions of the Cassandras* who, 30 or more years ago, warned what would happen if healthcare were marketed as a tradable item. The patient-clinician relationship would be destroyed. Charity would disappear. Healthcare would become more expensive to pay investors and would be rationed (probably by price). Drug companies, insurance companies, and healthcare plan managers would make out like "bandits." Insurance would become unaffordable to greater numbers of people.

Needless to say, this is precisely what is happening. Employer-sponsored health insurance plans are a major source of money keeping the system afloat.[1] Employers are not necessarily legally obligated to provide health insurance to their employees, but these days they do so as a benefit. And whenever this benefit is part of a union contract, it can be curtailed or even removed every few years during renegotiations. Industrial employers see their profits and competitive edge being decreased by the amount they must pay toward medical care, whereas the union members regard their health insurance as a prime necessity to maintain their safety and freedom from ruination in the event of catastrophic illness.

Parts of this benefit have been eroded by the demand for larger co-payments and the denial of certain treatments as medically unnecessary. The fear is that our current method of delivery has become dependent on employer-sponsored insurance; if the benefit is reduced in value or becomes unaffordable, the system could collapse.

Perhaps these issues have had one beneficial effect, in that the Business Round Table's Leapfrog Group initiative is setting standards to improve patient safety in hospital care, including the availability of critical care credentialed personnel in intensive care units, computerized order writing, outcomes-based referrals of patients for major procedures, and so on. Unfortunately, these efforts do not get to the root of the expense problem, nor do they adequately address the fact that marketplace competition is essentially breaking healthcare delivery.

Healthcare as a Commodity

Not many people are above the pressures of politics. Few can hold out against the parts of the organized healthcare delivery system that pay lip service to being "patient-centered" while simultaneously engaging in behavior that bespeaks their concern for the financial bottom line. In fact, patients are now regarded as "billing opportunities" who can enrich the system until their insurance runs out.

A few years ago, Marcia Angell, a long-time advocate of more rational healthcare delivery, pointed out the disastrous effects of treating healthcare as a commodity.[2] Instead of marketplace competition bringing down the price of goods and services that patients need, prices have gone up. And the more expenditures go up, the more profits are to be made. Insurance companies, health maintenance organizations, and medical centers are in fierce competition with one another for patients

* Cassandra, daughter of King Priam and Queen Hecuba of Troy, was given the gift of prophecy by the god Apollo. When she did not return Apollo's love, the god put the curse on her that she would be forever disbelieved. Among her unheeded prophecies, she predicted the fall of Troy to the Greeks, warned the Trojans not to bring the wooden horse into the city, and predicted the death of her master, King Agamemnon, if he went home to Mycenae.

and the dollars they bring in; each group insists on having the latest, most expensive, most high-tech procedures and investigations. The result is that per capita healthcare expenditures in the United States are more than double the average in other advanced countries. And these expenditures continue to rise, despite the fact that roughly one seventh of the population does not have insurance and many more possess inadequate coverage to meet their needs should they become ill. These incredible expenditures do not seem to promote better health. The United States does not fare well as a "first world" country in statistics ranging from infant mortality to longevity. Where does the money go?

Angell[2] points to insurance schemes that skim 10% to 25% off the top before using up money for promotion and administration, trying to recruit healthy people, and denying the sick (poor risk). The result is that only 50 cents of every dollar contributed is actually used for direct patient care. Angell argues that this country cannot afford to go on any longer without a single-payer system, noting that Medicare runs with a mere 3% overhead. Such an overhaul is not likely with the current political leadership, who seem to have no mind to take on the insurance industry or have a large stake in it. The administration already has caved in to Big Pharma and to the insurance industry, creating a Medicare drug plan fiasco that has increased the nation's bill for medications and that includes the insane rider that there will be no competitive bargaining over the prices (a blank check). This is yet another example of how the introduction of middlemen raises healthcare costs for everyone.

Regionalizing Complex Care

The "cottage industry" approach to healthcare delivery leads to a wasteful system with duplication and reduplication of product lines when only a few providers would be sufficient. Nowadays every major center feels obligated to transplant hearts and livers (expensive but remunerative procedures), to provide the most advanced cardiac arrhythmia devices and catheterization, and to have the highest technology in imaging, even if these services are available in neighboring institutions just a few miles away. For hospital medicine, this is where the money is (or where it *goes,* perhaps). The power players are now the cardiac surgeons (who, incidentally, have always been in this position), the transplant surgeons, the invasive cardiologists, and anyone else who performs a large number of expensive (ie, remunerative) procedures. This is financial irresponsibility.

The fragmented healthcare systems in place at the moment are far from perfect, with their tendency to disallow care where it is needed most, but they do need to maintain solvency to survive. Survival in the marketplace is being achieved by expanding the business to keep ahead of the competitors by offering more expensive and expansive high-end services. Although this circumstance drives up costs, it also ensures institutional viability. And it may explain why the United States has become the most medicalized and medicated country in the world.[3]

Trying to provide all things to all patients can decrease the quality of care. If the volume of patients in a service is too low, then those patients tend to have poorer outcomes. This is well known for more complex surgical procedures, but institutional volume recently was found to be important as an outcome predictor for patients with similar Acute Physiology and Chronic Health Evaluation (APACHE) scores who require mechanical ventilation as well.[4] This provides further argument for the regionalization of complex care.

Living in a Contradiction

We are living in a contradiction. The marketplace has produced a medical system that many cannot afford, while at the same time it is so expensive that there are considerable sums of money to be made in it. Even now, investment firms are airing radio advertisements that tout the healthcare system as an opportunity for making money. With the government "pouring" $42 billion into Medicare this year, reputable financial advisers offer to manage investors' money through stock purchases that offer the best return on healthcare portfolios—yet another unfortunate example of taxpayer dollars being used to enrich the "haves."

There is a topsy-turvy aspect to this system: the more resources that are put in, the greater the profits, and the greater the access to remunerative procedures of marginal worth, though with the possibility of a less beneficial outcome for patients. During the boom years of the 1990s, the economy seemed perturbed by but ultimately accepted the high cost of the healthcare business. Now that the economy has gotten tougher to live in, tolerance for those high costs has decreased.

Runaway technology is nothing new. It has been known for some time that much of what we do in critical care—and medicine in general—has surprisingly little data to show beneficial outcomes. In the early 1970s, for example, pulmonary artery catheters were introduced as a high-tech way to measure left ventricular filling pressure and cardiac output. Large amounts of time and effort were expended at critical care conferences such as AACN's National Teaching Institute on the care and insertion of catheters (a development that was supported heavily by manufacturers), with more on the usefulness and data interpretation in treating the cardiac and shock patient. In 1979, James Dalen[5]

pointed out that after nearly a decade and the expenditure of $2 billion, not one published trial showed that the pulmonary artery catheter changed patients' outcomes. Critical care practitioners continued to use pulmonary artery catheters extensively for more than a decade, with major specialty society recommendation,[6] despite the lack of a worthwhile evidence base.

Even though we could not get the evidence, we could not believe that the procedure and the information we derived from it did not make a difference in patients' care. To this day, pulmonary artery catheters are still inserted into patients in some cardiac surgery programs, even though available data suggest that mortality and morbidity could be higher as a result. One wonders whether the use of these catheters would have diminished sooner if the procedure had been less well remunerated. In any event, use seems to have declined spontaneously as fewer intensivists have found the information worth the effort. More recent data, however, suggest that our sickest patients (those with APACHE scores ≥ 26) might do better if the information from this invasive monitoring were made available.

Perhaps one of the saddest aspects of the competitive marketplace is the erosion of trust in the relationship between the specialist and the patient. The perceived need for more procedure-related income to remain viable has invaded many parts of our system. How can patients feel comfortable that they really need a recommended medicine that has potential side effects, a cardiac pacemaker, a mastectomy, a radical prostatectomy, a heart operation, a laminectomy, or some other equally invasive procedure, when the evidence for improved outcome is dubious? Patients read in the press about how poor the evidence is for many of the common treatments, how much more frequently procedures are done in the United States than elsewhere, and how results stemming from this excess are not superior.

In a *Business Week* cover story titled "Medical Guesswork," Dr David Eddy, a leading proponent of "evidence-based" medicine in the early 1980s, is lauded for his efforts to show what treatments are most effective and how the newest and most recommended treatments may not be best for the patient.[7] The author discusses some of the reasons that those with a vested interest in expensive technology or operations may be reluctant to use simpler and cheaper management, even when outcomes are as good or better with such cost-saving measures.

What's important is that the *Business Week* article was written for public consumption. It probably upset some of our patients and colleagues and made others ponder the ethical nature of our practice. Paraphrasing the standard courtroom oath, we do not have "the whole truth" about what we do in medicine. In our view, the *Business Week* revelations brought home the crying need for unbiased opinion, the need to get as far as possible as soon as possible from the marketplace economics of healthcare delivery, and the necessity that our practices be evidence based.

Envoi

Nearly a century ago, George Bernard Shaw began his outspoken "Preface on Doctors," the introduction to his satirical *The Doctor's Dilemma,*[8] with these words: "It is not the fault of our doctors that the medical service of the community, as at present provided for, is a murderous absurdity. That any sane nation ... should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make you despair of political humanity." He continues: "The more appalling the mutilation, the more the mutilator is paid. He who corrects an ingrown toe-nail receives a few shillings: he who cuts your insides out receives hundreds of guineas, except when he does it to a poor person for practice."

Most importantly, perhaps, Shaw reminds us that "[s]candalized voices may murmur that these operations are necessary," adding skeptically, "They may be. It may also be necessary to hang a man or pull down a house. But we take good care not to make the hangman and the housebreaker the judges of that."

The statements and opinions contained in this editorial are solely those of the Editors.

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