THE VIEWS OF THE MEDICAL PROFESSION*

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IN this presentation I shall seek to establish two central points. The first is that the physician's responsibility in addressing each of the three great topics of the health policy debate—namely, quality, access, and cost—varies considerably. The second is that the physician's primary role in addressing the issue of access is to ensure that medical services are utilized appropriately.

One continuing issue in health policy is that of quality. Indeed, the title of the Academy's 1981 annual health conference was "Struggle for the Assurance of Appropriate Medical Care," and that of the 1975 conference "The Professional's Responsibility for the Quality of Care." The medical profession's responsibility for the quality of health care is, I would argue, both primary and direct. It is *primary* because the physician, both by training and experience and by ethical responsibility, ultimately is concerned with the patient's well-being; it is *direct* because the physician has to a significant extent control over the process of care the patient receives.

Quality assurance and physicians' participation in it is not new. The ancient admonition "First, do no harm" begins to state the ethical basis for physicians' quality assurance behavior, and physicians' training has for years begun to provide the knowledge base for responsible medical practice. Most physicians individually strive to achieve and to maintain the highest standards of clinical practice, and all medical professional societies pledge to uphold those standards. Certainly, as studies by the Congressional Office of Technology Assessment have concluded, the determinant of the vast majority of individual clinical practices and the evaluator of those practices is the individual physician. As a society, we have throughout history largely entrusted the individual physician with the

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responsibility for clinical decision-making and for the assurance of the quality of those decisions.

In comparatively recent times physicians collectively have taken on additional responsibility for the assurance of appropriate quality of care. John Affeldt, in his presentation at this conference last year, outlined that collective activity. In 1917 the American College of Surgeons, stimulated by the work (and, as some would have it, the peskiness) of a young Boston surgeon, E.A. Codman, founded the Hospital Standardization Program. This program, utilizing predetermined but largely input-oriented standards, hospital visitation and evaluation, and compliance with the standards as a condition of approval, for more than 30 years comprised the most organized approach of the medical profession to assuring the quality of hospital care.

In 1951, because of the increasing financial and administrative burdens of establishing and applying the Hospital Standardization Program, the American College of Surgeons joined with four other professional groups —the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association—to create the Joint Commission on Accreditation of Hospitals (JCAH). Initially, the JCAH, as had the American College of Surgeons program before it, emphasized input standards—standards that related to the facilities within which care was provided. Over time, however, methodologies developed by physicians and other health professionals made possible a shift in the emphasis of the JCAH so that the process of care and, to some extent, its outcomes could be evaluated. The Joint Commission stands today as an excellent example of how the health professions maintain the responsibility of the profession: the responsibility to set its own standards and to evaluate itself against those standards. Professional Standards Review Organizations are a further example of how at least some members of the medical profession accepted their responsibility for quality assurance through both medical care evaluation studies and review of the appropriateness of service utilization.

A final area in this by no means exhaustive listing of the profession's activities in assuring the quality of health care is that of medical education. Beginning at least with the Flexner report at the beginning of this century and based on the (albeit tenuous) assumption that the quality of physicians' education bears a relation to the quality of care their patients receive, the medical profession has emphasized education—undergraduate, graduate, and continuing—as a means to enhance quality of care.

We physicians have made nearly a fetish of education at every level. There are accrediting councils in graduate medical education and in continuing medical education, residency review committees in the specialties, board certification in dozens of specialties and subspecialties. Nearly every hospital maintains some organized continuing medical education, and my own organization—the American College of Physicians—sponsors hundreds of continuing medical education programs each year in addition to publishing its journal, the *Annals of Internal Medicine,* and the widely subscribed Medical Knowledge Self-Assessment Program. Even this present conference has been approved for 11 hours of category I Credit for the AMA Physicians Recognition Award.

Now, the point of this litany is that the medical profession has had a long-standing role—one that is both primary and direct—in attempting to assure high quality medical care. This role, I believe, stands in clear contrast to the role that physicians play in assuring access to health services. That role, I believe, is both secondary and indirect. It is *secondary* both in that physicians are not especially qualified by training and experience to design and to maintain systems to enhance access and in that the major legal and ethical prescriptions confronting physicians relate to the care of *individual* patients. It is *indirect* in that individual physicians, by and large, do not control the institutions and resources that are the major determinants of access: hospitals, the reimbursement system, and the economic and geographic status of patients.

Before further discussing the issue of access and physicians' role in it, for completeness I would mention the cost issue, returning to cost also in the context of access. (Parenthetically, I would think it not unlikely that next year's conference of the Academy would have the title "Struggle for the Assurance of Cost-Effective Health Care.") The cost issue is one in which the physician's role is secondary, albeit direct, using my previous terminology. It is *secondary* because the issue of cost has been in the physician's mind—and I think in the patient's mind—always secondary to the quality of care. It is *direct,* however, because the physician controls what is spent—the seller in an odd market deciding what the buyer will buy, how much it will cost, and where it will be bought.

Now, to return to the physician's role in relation to the issue of access. That role has changed over time. In particular, it has changed as medical care has become more complex, and, importantly, as medicine increasingly developed the ability to diagnose and to treat disease successfully. Until the early part of this century, the physician was either bystander or

dangerous: bystander because of the ineffectiveness of drugs or their lack, dangerous because of the risk of surgical intervention. With the development of anesthesia, improved surgical practice, and effective drugs, the physician, in a relatively short period of time, came to hold tremendous actual power—the power to diagnose accurately, to treat successfully, and to apply a huge and growing array of medical services. Prior to this time, the available physician *was* accessible. The physician could hang out a shingle, and, if geographically available, would be economically accessible. Cost was not such a problem because of the nature of the available services—those services were few because treatments were not often effective and they were not of high cost because they were not technologically intense nor did they prolong life palliatively to any extent. In such an environment, the physician and hospitals could and did provide care at reduced rates or free to those who could not afford the full amount.

By the 1930s and 1940s, however, medicine's ability to diagnose and to treat successfully began to alter access to new and improved medical services. As services increased in number and complexity, and as some services, primarily surgery, became more personnel and technology intensive, demand for services began to exceed supply, and two elements of access—availability and economic access—began to decrease. Partly for this reason, health insurance began to grow—initially to provide ability to pay for expensive surgical procedures. The availability of insurance provided a means of economic access to services and at the same time tended to relieve the physician, in part, of a responsibility directly to assure access.

These same trends—the development of new and more complex and more costly services—in conjunction with the growing social role of government led, in part, to the passage of Medicare and Medicaid in the mid-1960s. Medicare and Medicaid were a societal decision that society had a major responsibility to assure access to care for segments of society in medical need—largely the elderly and the poor.

Thus, other elements in society—patients, through purchase of insurance, and society itself, through government programs—began to assume responsibility to assure economic access to care. Soon many other governmental programs began to increase the availability of physicians: capitation payments to medical schools to correct a perceived physician shortage; developmental funds and other incentives to correct perceived imbalances in specialty distribution; funding for physician extender programs; a National Health Service Corps to correct perceived geographic

unavailability of physicians—and on and on. At least in part, I would argue, it was medicine's successes—its ability to diagnose and to treat—that enhanced the profession's direct emphasis on and role in quality assurance in all its facets and diminished the physician's direct role in assuring access.

Now, I have used this bit of history not to argue for diminished responsibility for the medical profession but to argue for the acceptance of an increased responsibility of *all* affected segments of society in assuring access to care and to argue for an *appropriate* role for each of those segments, including the medical profession. We cannot go back, nostalgically, to that era in which the physician hung out a shingle and treated all comers regardless of ability to pay. The assurance of access to care is no longer solely the physician's responsibility. Society has changed too much. And, perhaps more important, medicine and what it can accomplish has changed too much.

What is the responsibility of the medical profession for assuring access? In my view, it is to assure that the individual services provided individual patients are each appropriate for the circumstance, critically to examine what it is that we as physicians do with patients so that clinical decisions are based on the best information possible, and to recognize fully that all parties with a legitimate interest in health care have a legitimate role to play in assuring access.

Assuring appropriate utilization of services is a major role that an individual physician can play in assuring access to services. In using medical services parsimoniously, an individual physician upholds the ethical obligation to the patient and at the same time conserves finite resources for others to use.

Critically examining the medical and cost effectiveness of services is an appropriate role of medical professional societies. The American College of Physicians, for example, has for six years cooperated with the Blue Cross and Blue Shield Associations in the Medical Necessity Project to provide information and opinion on the value of some 100 procedures. In an expanded activity, the Clinical Efficacy Assessment Project, the College has for the last year made recommendations to its membership, other physicians, patients, and others on the safety, efficacy, and effectiveness of various internal medicine procedures. Such an activity is an example of how the profession can enhance the quality of the clinical decisions of its members and indirectly enhance the access to limited resources.

Finally, the medical profession must recognize the legitimate roles of

others and participate with them in assuring access to care. Too often in the past organized medicine has spoken in reactive self-interest and not in a balanced and responsible way. We physicians have a direct and primary role in assuring the quality of medical care; we have but an indirect and secondary role in assuring access to that care. Others have legitimate roles and should be encouraged to assume them. The opposition of organized medicine to Professional Services Review Organizations and to health planning, for example, is as inappropriate as is the federal government's own attempt to escape its own responsibility and legitimate role in those areas. The time is past, if it ever existed, in which the medical profession alone could dictate health policy. The time is equally past when the government could avoid its own responsibility.

In an article in the March 19, 1982 issue of *Science* on the demise of the golden age of American medicine, the author states that the politics of debate—that is, medicine's response to social change and societal need—was the basis for a pervasive public distrust of the medical profession. As Congressman Waxman wrote in 1981: "When issues of importance to the health of the American people were debated [in Congress last year], where was the voice of organized medicine?" And as Assistant Secretary for Health Brandt asked just last week: "Medicine has been strangely silent on these larger issues; where is the statecraft of medicine?"

The responsibility of the medical profession is to fulfill its role in quality assurance and to assure the proper utilization—medically—of services. The responsibility of the profession in its relationship with government is to recognize government's legitimate role and to speak in a balanced way—on behalf of the health of people rather than on behalf of the profession's pocket.