Mene, mene, tekel, upharsin comes to medicine

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All the recent rolings and rumblings about the “hospitalist movement” prompt recollection of a biblical aphorism; the “writing that was written” (on the wall of Belshazzar’s banqueting hall) has become ever more perceptible. Having observed the evolution of our discipline for over five decades, I am stimulated to join the ever-growing legion of speculators mulling the future of our noble but embattled calling. I don’t love all that I think will happen, but I am optimistic that ultimately a better system of medical care than exists today will emerge.

Within the next ten (perhaps twenty) years we will evolve a two-tiered system. Outpatient care will be delivered by “primary care providers.” These will consist of an amalgam of nurse practitioners, nurse-midwives, and physician assistants, who may or may not work under the supervision of a family physician. The family physician will become the captain of the primary

Daniel 5:1-31. Belshazzar the king made a great feast to a thousand of his lords, and drank wine before the thousand. . . . In the same hour came forth fingers of a man’s hand, and wrote over against the candlestick upon the plaister of the wall of the king’s palace: and the king saw the part of the hand that wrote. Then the king’s countenance was changed, and his thoughts troubled him, so that the joints of his loins were loosed, and his knees smote one against another. . . . And this is the writing that was written, MENE, MENE, TEKEL, UPHARSIN. This is the interpretation of the thing: MENE; God hath numbered thy kingdom, and finished it. TEKEL; Thou art weighed in the balances, and art found wanting. PERES; Thy kingdom is divided, and given to the Medes and Persians. . . . In that night was Belshazzar the king of the Chaldeans slain. And Darius the Median took the kingdom, being about threescore and two years old.

care provider (outpatient) team. Over time, the distinction between M.D., D.O., R.N., and P.A. will blur and diminish. They all will be primary care providers. Their training will be consolidated, standardized, and conducted by academic health centers, tailored to the needs of ambulatory medicine, perhaps even further refined to meet specific rural or inner-city requirements.

In the early years, non-physician/osteopath primary care providers, working in less felicitous geographic sites (where most physicians have always been reluctant to live and practice), will function in virtual autonomy. They will be obliged to follow diagnostic and treatment protocols based on the latest evidence-based information. Such data will be periodically refined, updated, and modified to ensure established standards will result in appropriate punitive action, up to and including license suspension. (A similar mechanism will be established for hospitalists representing all specialties and subspecialties.)

All hospital inpatient care will be conducted by internists and specialists in other disciplines (the former now called “hospitalist-generalists” and the various subspecialists — now called “hospitalist-specialists” — designated in cardiology, infectious diseases, general surgery, obstetrics/gynecology, et cetera). Initial management will be performed by hospital generalists, who will triage consultations and referrals when indicated. All hospitalists will be salaried employees of their institution, income independent of individual “dollar productivity.” Salaries will be negotiated and established, based on age. All income and expenses will be controlled by the SPP working with states, academic health centers, and the primary care providers in whatever organizational structure that evolves from the current hodgepodge of management schemes. It will be compatible with the new, nonprofit (no shareholders involved) SPP.

Academic health centers will become the focal point of all health care delivery and illness prevention. They will be empowered by the SPP with the manpower and finances to ensure the highest quality of care in all institutions within their designated geographical area. These will include private hospitals, community hospitals, veterans administration, and military hospitals. Such innovation will require a revolutionary revision in current organizational arrangements, but such structures already exist to a limited extent in many areas. Over time, the system will be expanded and refined to ensure fair allocation of resources and mutually beneficial cooperation between institutions. In the final configuration, the academic health center will bear ultimate responsibility to ensure the quality of care.

The academic health centers will be subsidized completely under the SPP. Since all research and clinical faculty will be salaried, they will no longer be obliged to divert excessive time from mutually accepted criteria, by the Single Payer Program (SPP, see below) and the institution. (A peripheral benefit, incidental to these changes, will be a simple answer to the as-yet unresolved question, “What is an internist?”)

Primary care providers will be encouraged to “look in” on their admitted patients and provide the hospitalists with insight about important aspects of the nature of the patient’s previous management, personality, or expressed desires (for example, diagnostic and therapeutic preferences, concepts of quality of life, “end-of-life” desires, et cetera).

We will have evolved into an SPP, an extension of a modified Medicare system. Every citizen and legal immigrant will be covered (universal capitation will be augmented by a system of co-payments, adjusted through a realistic means-tested formula). Illegal immigrants will be covered for emergencies; their children will receive full coverage.

The ACADEMIC HEALTH CENTER... will ensure QUALITY OF CARE

Revised research and teaching. All pharmaceutical and medical equipment manufacturers (and perhaps any other commercial enterprises that profit from patient care activities) will be obligated, by law, to tithe a percentage of their profit to the SPP to help subsidize academic health centers and their satellite institutions.
One by-product of the new system will be a resurrection of bedside teaching rounds, with renewed emphasis on integrating the patient into the dialogue. Handheld computers will facilitate real-time, bedside access to all pertinent laboratory data. In time, there will be bedside access to other visual diagnostic aids, such as scans, radiographs, and electrocardiograms. Rounds will be enhanced by the presence of a clinical psychologist and pharmacist to sharpen appropriate discussions into psychological and pharmaceutical aspects of management. In every instance patients will be apprised, in language comprehensible to them, of the nature of the discussion. Sensitivity and discretion will be the watchwords governing all bedside encounters. The overall impact of teaching rounds will be positive for patients: they will always feel that their medical problems are receiving input from knowledgeable, sympathetic professionals.

Periodically, the SPP will conduct epidemiological surveys to determine the therapeutic and economic effectiveness of satellite hospitals and their responsible academic health centers in management of specific medical problems. It is well-known that hospitals (and physicians) with greater experience in specific areas (for example, coronary artery bypass surgery, organ transplantation, et cetera), so-called “centers of excellence,” produce outcomes considerably better than those with less experience. Therefore, there will be a concentration of referrals based on carefully and fairly evaluated performance. Duplication and redundancy of procedures that are found to be less effective in specific geographical areas will gradually be phased out. Transport by air or vehicle from peripheral hospitals or outpatient facilities to the nearest center of excellence that provides the specific service required will become part of an exten-
sive medical transportation network. This will be a function of the SPP, operating at no expense to the patient. Demographic and geographical factors will determine the location of effective satellite facilities, peripheral to the responsible academic health center.

Capitation and means-tested co-payments will mean that medical care will become more expensive for the affluent. But medical care will be viewed as a commodity (as are fuel, food, and housing), and costs will be dictated by fair market value. In addition, the SPP system will eliminate the financial disincentives that have helped undermine the moral imperatives of many managed care plans. There will be no financial benefit for primary care providers or hospitalist-generalists to avoid referring patients for appropriate hospital-specialist care. There will be no financial incentive to route patients to physician-owned pharmacies or other physician-owned treatment or diagnostic facilities. There will be no “end-of-the-month” pot of savings to divide, and no funds derived from purposeful or subconscious underutilization. Under the SPP, health care providers will not be allowed to own such facilities.

Of course, there will always be outliers: physicians and patients who will operate outside the SPP. But it will become prohibitively expensive to compete with the high standard of care that will exist within the system.

Finally, “alternative medicine” practitioners will be compelled by the SPP to compete with scientific medicine by requiring solid evidence of acceptable outcome and patient satisfaction. A major program of public education (utilizing every media channel) will be undertaken to increase the overall level of “scientific literacy.” Appropriate scientific education, emphasizing realistic “self help” (preventive) health habits, will begin in grammar school and become part of every secondary school curriculum. A determined effort to forestall the politicization of medical care by special interest groups will be undertaken. Under the new SPP program, characterized by reasonable access for all and uniform quality of sensitive, thoughtful, scientifically-based care in every part of the country, patients will no longer feel “medically disenfranchised” or neglected. They will no longer feel obliged to seek kindness and “listening time” outside the mainstream.

But there probably will be a period of considerable chaos before this nirvana is achieved. There may well be a long interval during which patients continue to invoke their “freedom of choice” to select health care providers. This will turn the “agora of medical care” into a turbulent, expensive marketplace, indeed. When all financial barriers come down and before the SPP and public education begin to bring scientific rationality to medical care decisions by patients, all payers will be obliged to pay for visits to all providers. There is already reimbursement for chiropractic, naturopathy and acupuncture in many states. The ultimate perversion of this situation will see herbalists competing with primary care physicians, chiropractors openly challenging orthopedists and physiatrists, crystal-gazers taking on psychologists and psychiatrists, and acupuncturists competing with all allopaths. Of course, to a certain extent this is happening now, but when political pressure forces universal reimbursement and any restraint exerted by existing reimbursement limitation disappears, the games will begin in earnest.

Over time, pragmatic empiricism (what works will be retained, what doesn't will be discarded), the imminent bankruptcy of the system caused by the profligate reimbursement mechanism, or a much higher level of medical literacy attained by the public will cause pretenders to fade from the scene. I am not sure which factor will dominate, or if there will be some felicis cent synergy. Note that I did not include scientific velocity among my criteria for the ultimate failure of nonscientific medicine. This is because many contemporary consumers of medical care believe they are sufficiently medically sophisticated (many through exposure to the checked information available on the Internet) to make educated choices. And besides, they just distrust doctors! There is partial truth in both statements. I would like to think that a more medically literate public will be our ultimate salvation, but I am far from sanguine. In

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Healing at Diamond Lake

Before the ice was gone
I was back, waiting
for the water to be troubled
by quidling mallards,
by diving mergansers,
by the signs my mind
could fix upon like
fingers upon the rosary
when fear or fever
has stifled the mind.
There is a feathered grace
in the flight of terns
dangling from seasonal strings,
floating, falling on mimons,
from suddenly slackened cords,
rising from the splash fed
and gleaming.

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darker moments, I suspect the return to rationality will turn on hard-nosed, practical outcome happiness (or unhappiness) of patients, or down-and-dirty economic necessity, rather than the clear virtue of sound medical science.

Another related problem threatens the future of American medicine: the alarming decline of physician-investigators committed to basic or clinical research. According to the Association for Patient-Oriented Research, the number of first-time applications by physicians for National Institutes of Health (NIH) research grants plummeted 31 percent between 1994 and 1997. If this pattern continues, there will be no first-time applicants with M.D. degrees in 2003. Some say we should leave the field of medical research to those with doctorates in basic sciences. I think not. This would certainly widen the already existing breach between bed and bench. So why are fewer physicians selecting careers in research? The reasons probably include (1) public pressures on medicine to focus on primary care rather than specialization; (2) economic disincentives (that word again), such as the growing debt burden of medical graduates and the modest stipends of postdoctoral trainees; (3) growing instability of NIH support and perceived study section bias against patient-oriented research; and (4) the explosive growth of managed care. A most formidable list.

I have a suggested solution. We must expand, revitalize, and reorient the National Health Service Corps (NHSC). This could solve several problems. It will afford bright but poor students (especially minorities) the opportunity to come into medicine without incurring debilitating financial indebtedness. I feel such an infusion of fresh blood could provide the same tide of intellectual and spiritual revitalization that we see when eager new immigrant populations enter the country.

When the time comes for their repayment (after medical school or postgraduate training), they will not have the option of “buying out” with loans. That would defeat the purpose and spirit of the NHSC. These new physicians (or primary care providers or perhaps, even, some hospitalist-generalists and hospitalist-specialists) will be assigned to underserved areas, where their particular skills are needed. Those who have demonstrated a talent and desire to do research will be allowed to repay some or all of their time by conducting postdoctoral bench research or clinical investigation. NIH study sections will be obliged to revise the granting process to acknowledge the critical importance of patient-oriented investigation. Thus, the new NHSC program would provide at least partial solutions to two vexing problems: acquiring health care providers for underserved areas, and encouraging more physicians to consider careers in medical research.

Admittedly, this is a cheeky, bare-bones (I will even concede, simplistic) sketch of what I believe many aspects of the ultimate system will look like. I am convinced that the many devils in the details can be worked out by thoughtful people, representing different disciplines in and out of medicine, who will be seeking a mechanism to ensure optimal care at a reasonable cost. If this pie-in-the-sky plan seems to have Orwellian overtones, it need not. The transition will be tumultuous and the inevitable bureaucracy must be anticipated and contained within reasonable limits.

Medicine will always be conducted on a human-to-human basis. But, to acknowledge the hard facts, over the years most of us became complacent; in many areas we lacked discipline. In our zeal to leave no stone unturned on behalf of our patients, we neglected the realities of fiscal responsibility. In our benignly paternalistic fashion, we did things “our way” for a long time. That is why the unwelcome nose of the managed care camel has managed to creep so successfully under our tent. Entrepreneurs sensed what I call a “golden vacuum,” a chance to fill a perceived need and enjoy a profit. Undoubtedly, managed care has brought a renewed sense of discipline and fiscal reality to medicine. But as it exists, it has too many warts. Major modifications will occur, retaining some of the good things we have learned, but eliminating those that cause grief. The changes will be facilitated by implementation of the SPP — when those infamous mantras of “obligation to our shareholders” and “incentives and disincentives” have been expunged from our lexicon.

The intangibles of compassion, caring, and patient advocacy will always be a function of the sensitivity of the health care provider. These virtues must always be coupled with good medical science. I think it will all come to pass once medicine has survived the revolution and matured, to evolve a true partnership with those for whom we care.

Well, on reflection, perhaps it will take a bit longer, maybe three decades. What do you think?

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Ode to a Managing Editor

Dear traveler
whose path crossed mine
but a few times.
You left an imprint on my soul.

I'm writing to extol your radiant mind,
your poet's heart.
Before you
I never knew that editing could be such art.

Eric Pfeiffer, M.D.*

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