Editor's Notes

Cost Containment and Quality of Care: The Illusory World of Magical Thinking

By Stephen Jackson, M.D., Editor

Returning from the World Magic Seminar (held in Las Vegas, the uncontested magic capital of the world), I glanced at *USA Today* (did you expect the *New York Times* or *Wall Street Journal* or *n+ 1* in Vegas?), and lo and behold, the headline beckoned: "Health Care Tab Ready to Explode." Wow! A rude awakening from the world of magic, illusions and tricks (magical, of course). Or was it? Unlike the mysterious nature of magic, it is rather easy to see through the thinly disguised veil of our national *mantra* of **"more quality healthcare for more people for less money."** After all, our politicians and policy makers already have mastered their art of deception and sleight-of-hand distraction so that we, as a nation, are led to believe that we can afford to continue, indefinitely, to satisfy our seemingly insatiable healthcare demands.

> *As through this world I ramble.*
> *I see lots of funny men;*
> *Some will rob you with a six-gun,*
> *Some with a fountain pen.*
> —*Woody Guthrie*

The Centers for Medicare & Medicaid (CMS, formerly HCFA) has predicted that our nation's tab for healthcare, already the highest per capita in the industrialized world, should tally $3.6 trillion by 2014. This would represent about 19 percent (increasing from the current 15.4 percent) of the Gross National Product (GNP). Moreover, these figures are *not* adjusted for inflation. Growth in healthcare spending over the next decade is predicted to outpace economic growth, and this is worrisome to our government because it will be incurring an enlarging share of these costs, rising from 45.6 percent in 2003 to 49 percent in 2014. Per capita expenditures for healthcare will jump from $6,423 to $11,045. This clearly is not a sustainable progression, unless, of course, you believe in the power of magic. Will our government acknowledge that a requisite to controlling healthcare costs will involve 1) *limits* not only on quality of care, but even on healthcare itself (rationing, that politically incorrect R word, already thrives in various forms of disguise), and 2) *limits* on reimbursements from both government and private insurers? Of course, we as a nation *could* decide that we want to spend an increasing percentage of our GNP on healthcare, but that has to be an informed decision, one that involves transparent choices on how we would choose to spend the remainder of our nation's overburdened and shrunken coffers. Rest assured that

state public healthcare programs, already under horrific strain, seem likely to require more federal assistance, something antithetical to the Bush Administration's proposal to cut $40 billion from the federal share of Medicaid over this coming decade.

We physicians claim to be committed to the goal of providing a cost-effective quality of healthcare for our patients. In the present gun-barrel socioeconomic milieu in which physicians struggle to contain costs as we practice under siege from federal and state legislators and regulators, private insurers ("for-profits" skimming off as much as one-third of the premium dollar), consumer advocates, malpractice lawyers, institutional administrators, accreditation bodies and internecine competition, management of the cost of healthcare inevitably is located at the crosshairs of conflict and debate. This intensifying struggle is undermining traditional medical ethics and values, as for example, controlling expenditures on individual patients in order to benefit the entire population of those patients; and limiting costs by eroding physician autonomy and emasculating the covenant of trust between physician and patient. Each year, by virtue of renewing our ASA membership, we "agree to adhere to the ASA *Guidelines for the Ethical Practice of Anesthesiology."* This *binding* commitment signifies our determination to maintain our moral and ethical base as we manage the costs of anesthesia care by "placing the patient's interests foremost, faithfully caring for the patient and being truthful."

> *The phony exists in every vocation and has been vividly caricatured. Yet, that which is comically ridiculous in other professions appears tragic when enacted by the physician. For he, more than any other man, finds his customers (the patient) completely at his mercy–they having placed themselves so deliberately. And, when he distorts the facts of a case for his own rather than the patient's gain, he violates his exclusive position of trust.*
>
> *–Oscar Creech, Jr., M.D.*

In this issue of our *Bulletin*, Drs. Kofke and Rie's sojourn into the ethical debate of whether cost containment initiatives with unknown healthcare outcomes are, in fact, *research* on patients *without informed consent* (see pages 33-39). If true, such cost containment initiatives and measures–not heretofore challenged on such controversial grounds–might well qualify as violations of the standards for informed consent (as espoused by the Nuremberg Code and the Declarations of Helsinki) that should be normative for health-related research funding, peer review publications and provider accreditation. In fact, it is difficult to contest claims that some well-subscribed and institutionalized cost containment strategies

have incorporated a process of progressive, non- consented continuous quality *decrements*.

> *The practice of medicine is an art, not a trade; a calling, not a business.*
>
> *–Sir William Osler, M.D.*

We work daily with the pressures of cost containment weighing heavily upon us. This culture of cost containment is the slowly evolved product of a "slippery slope" of systematic changes imposed on our specialty, even intruding on those practitioners whose steadfast conviction and moral resistance has characterized their patient advocacy. Indeed, our current anesthesia practices incorporate a *faith* that relies on our cost-conscious intellectual adjustments and rationalizations, and a *faith* that our clinical skills and compensatory responses will minimize the likelihood of adverse or sub-optimal outcomes.

We routinely are confronted with ethical challenges relating to our duty to our patients, our responsibility of placing their interests foremost. Has there been a preanesthetic medical workup adequate enough to empower us to provide a safe anesthesia? Have we implemented a preanesthetic system that reliably provides us with access to this information? Do we refuse to proceed if we don't have what we want, despite the pressures to proceed *now*? Do we *know* the human being we are about to anesthetize, and do we demand to take whatever time and measures are necessary to establish the sacred and *therapeutic* doctor-patient relationship? Do we empathize with our patients' plight of being ill, and if so, is such empathy manifest to our patients? Do we obtain an unfettered informed consent, one free of any whisper of evasion, manipulation or coercion? Do we refuse to prioritize personal gain (financial benefits, ego gratification, or personal convenience) to the detriment of patient care? Do we, in truth, challenge the prevailing power structures to ensure that costs, be they to the healthcare system or to us individually, will not trump the needs of our patients?

> *Generational Gap: Bending the Minds of Anesthesiologists*
> *1970: Do not proceed with the anesthesia unless you can prove it is safe to do so.*
> *2000: Proceed with the anesthesia unless you can prove it is not safe to do so.*

Do we nurture professionalism, cooperative spirit, effective communication and mutual respect, and shepherd them among our colleagues and co-workers such that patient care reigns supreme? Have we initiated an institutional beta- blockade program for the perianesthetic period? Have we enlisted institutional support for

an outcome-based, cost-effective postoperative pain management service? *Do we incorporate and utilize to the fullest degree our newly recruited, fellowship-trained anesthesiologists in a manner in which their sub-specialty expertise and clinical acumen would elevate quality of care, or do self-interest, ego-inflation and arrogance of established members–or rigid group dynamics–stifle overall institutional advancement of clinical skills?* Do we participate fully in medical staff and institutional functions that serve to improve quality of care?

> *Being unable to make what is just strong, we have to make what is strong just.*
>
> *–Pascal*

The professionalism of the physician community is a morally based, structurally stabilizing protective force in our society. We are duty-bound to protect vulnerable persons and social values (although this certainly is not our exclusive province). Our professionalism requires us to altruistically serve the interests of the patient before and above our self-interest. Our professionalism aspires to accountability, and to commitment to the highest standards of service and behavior. There is, of course, a cost to us personally to uphold quality of care. However, truly caring and succeeding at this noble endeavor reaps rewards that makes the practice of medicine an incomparable delight and a source of personal fulfillment.

> *The care of the patient is caring for the patient.*
>
> *–Francis Weld Peabody*

CSA Hawaiian Seminar

January 23-27, 2005

Hyatt Regency Hotel
Kaanapali Beach, Maui

Don't forget to sign up for the luau!