

# The Great Game

By Jason Campagna, M.D., Associate Editor

*It was called “The Great Game,” and it referred to the epic imperial struggle for supremacy in 19th century central Asia. For well over 100 years, The Great Game occupied the minds of the best men in the most powerful governments on the planet. Today, another Great Game is afoot—and it refers to who will control the vast resources and wealth associated with the entire medical superstructure.*



**L**ike the Great Game of the 19th Century, there are concrete and tangible rewards to be had by playing—and winning—today’s version of The Game. Then, the rewards were oil, natural gas, and other precious resources, along with the money that derived from their control. Today, the prize is the medical superstructure in its entirety. Such control allows one to lay claim to one of the most benevolent offerings one human can provide another—medical care. With this claim comes great power: power over people, and, more important, power over vast sums of money. Like two sailing yachts dancing around one another before a match race, or two prize fighters circling one another in the ring, the current players in the New Great Game are circling, watching, thinking. Like any game, some potential players remain on the sideline. Some do so for strategic reasons, while others do so out of fear. During this time, the active players make mistakes, joust with one another and withdraw. Most important, however, they learn—learn better how to play the game, how to attack their opponents with force and brutal efficiency, and how to lie low and wait when in danger. In short, these players are getting quite good at the game, while those on the sidelines are not. This does not bode well for those observers.

For physicians, these details of the Great Game, and understanding the players and the observers, are vitally important. The *key issues*, unfortunately, are that physicians do not like this game, they are not very good at playing it, and, sadly, they are one of the most conspicuous of those groups now on the sidelines. The reasons that physicians are such reluctant players in this drama are largely historical, and, not surprisingly, they are also misguided and antiquated. Physicians have always believed, with the kind of fervor usually reserved for religious zealots and political fanatics, that we are the rightful and just center of the medical universe. Not only is this notion false at the present time, it also has no basis in historical fact from previous eras. Although physicians, however briefly, have recently enjoyed such a preeminent position in the healthcare

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infrastructure, such a position of honor and respect in the world of medicine has rarely gone to doctors. Even though modern-day clinicians will wax nostalgic about the mythical days when the first medicine man had the good fortune to recite an incantation just prior to his patients equally fortuitous—but unrelated—recovery, this imagery, and what it represents, has no relevance to any position of power or honor that modern physicians may or may not hold, or have held.

It seems, sadly, that everyone playing the Great Game knows this fact; everyone except doctors. Here rests the important fact. If indeed we would like to become players in this game, there are some things we must just simply acknowledge and then move on. Chief among these is that there is nothing inherent in the concept or title of “physician” that grants us any cultural authority, economic power, or political influence. Furthermore, if we sense some recent loss or deficit in our value in any of these areas, we must therefore look to some extrinsic force that has resulted in our profession being divested of such privileges. The sooner we acknowledge these truths, the sooner we can progress toward asking the singular most relevant question facing our future as physicians: *What are those extrinsic factors?*

Before addressing that question, however, we have some other painful truths to make clear. There was a time when medicine did enjoy significant cultural authority, and this authority was genuine. Our authority brought with it a substantial amount of economic and political power. But, this state of affairs did not happen *ex vacuo*. Rather, it was gained by establishing our legitimacy through licensing, through the formation of medical societies, and through the development and accreditation of a uniform method of medical education. No less important was the fact that people—that is, our patients—depended upon us. Specifically, at one time the only access to the medical system was through physicians, so patients required us for medical care. This brief interval of our history was somewhat rare because in prior years, many “practitioners” of dubious value were also involved in “the medical arts,” and similarly in current years, one could argue the same is true again. Today, however, unlike in the past, some of these practitioners have also conferred upon their specialties the “branding” of authority: they too have specialty societies, mandated licensing and uniform education. How then to distinguish among us? In the recent past, our cultural authority had negated the need to address this question in any serious or thoughtful manner. We were superior to other practitioners, *a priori*, simply because we were physicians. Those days have long since passed us by. So then, if the observation is that we have seen a massive erosion in our cultural authority contemporaneous with an equally but more unpalatable diminution of our economic and political power, we must recognize the painful but crucial truth that our special economic and political status is

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untenable. This is the chessboard that we must accept at whatever time we finally engage in the Great Game. Clearly, we are now at a distinct disadvantage.

When physicians make the observation that, for example, we are bearing the burden of ever more regulations with a consistent downward pressure on our incomes, we must focus our minds and realize that these are mere *symptoms* of the actual problem, the loss of confidence that the general public has in physicians. This is an important derivation and one that is not necessarily self-evident. **Doctors are dependent upon patients for their status in society.** Conveniently for us, in the recent past, whilst patients were dependent upon us for access to the system and the provision of their care, they were also sufficiently satisfied with their care that they imparted to us the cultural authority (and all of those attendant fringe benefits) by default. To our great and sad collective misfortune, however, in a trend that began with the use of the stethoscope and is evident today in the world of catheters and stents and MR scanners and virtual colonoscopies, we have reduced our visibility to the patient as a purveyor of a uniquely important skill set. We have increased our dependence upon capital and machines and, in doing so, have disrupted the long-held symbiotic relationship we once shared with our patients. We no longer really need them to practice our craft and, tragically, they fully understand that they no longer need us. Without our patients, we have no authority. Without authority, physicians are little more than highly educated commodities in a race to the bottom of the value chain.

Unfortunately, loss of patients' trust is just a part of the answer as to what external forces are responsible for our loss of authority. The other portion rests in the conditions of the perverse and somewhat surreal-like world that we now inhabit. Specifically, the factors that have replaced patients as our source of authority: our increasing competitiveness and financial savvy and our vocal advocacy for patients offer us neither authority nor a mechanism to demonstrate our worth and value. The current medical marketplace has not a care for our feeble attempts at financial independence, and our patients no longer believe us. No one has any sentimental or historical reason to need us—and, with a dash of salt in the festering sore, there are no present market pressures working to include us. We have become marginalized by simply being passive observers in a highly dynamic and innovative world that we once inhabited as the epicenter of cultural and social value.

Thus, as these truths become more and more evident (and perhaps more agonizing to digest) to ever-increasing numbers of us, we are now clamoring for a seat at the table so we too can play The Great Game. Our continued misfortune, however, reveals that there does not appear to be any seats left for

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us at that table. The reason for this is again not plainly self-evident, but it does follow clearly from the above arguments. Patients do not see us as necessary because they understand very well that we no longer see them as worthy of our ethical and moral focus. They think, and not without some merit, that instead we simply see them as “the prize” in The Game. They rightfully and quite seductively realize that many, many persons and groups are vying for their attention and affection—and that physicians are simply one of those groups. They no longer see our aims as benevolent and altruistic, but instead perhaps as a bit self-serving and very shortsighted. Yet another important fact derives from this agglomeration of absurdities, and again it is one that everyone but us understands: the private interests of physicians alone are insufficient to sway society.

What next? Well, in plain-spoken vernacular, a powerful argument can be made that it is time for us to “ante-up.” In order to play the game, especially a game where it appears as if we may not hold an invitation, our ante has to be “attention grabbing.” Here is one plausible, but by no means singular, line of argument physicians could make to remind patients that, in fact, we are singularly qualified to merit their trust; we are, in fact, worthy of their dependence; and we, in fact, do hold their well-being above our own. To illustrate, I choose anesthesia because it is my field, and therefore one I know well. By way of example, let us state openly and clearly that we believe specialized training is needed to deliver a safe anesthetic. However, instead of proceeding immediately to enumerate all of the arguments for why such a practitioner who renders care should not be anyone but a licensed M.D. anesthesiologist, I would instead ask the following question: “Who says that a specialist needs to be a physician?” If, among physicians, we cannot answer this question, how can we debate it among a more diverse and hostile audience?

Posing this question makes it clear to those who engage in focused and meaningful thought on these issues that we as clinicians recognize a few things. First, that such anesthesia “practitioners who render care” have not always been physicians. Second, that forces that had aligned to make physicians the primary delivery vehicle for anesthesia care in the United States, namely safety and surgical complexity, have largely disappeared. So who says physicians must be those with the unique training? Although the question disarms, at least temporarily, our opponents, it also serves to focus our thinking. The ante is: either you bet that doctors are the only ones so qualified, or you bet that they are not. As a note of caution, the players at the table have been staking their chips on the latter option. This scenario makes plain a key strategic question, one that is applicable across our entire thinking in this area. If the expected value of our bet seemingly is already of negative value, why do we invest so

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much time and energy into a position that is unlikely to yield any positive expected return? Perhaps a more prudent and productive “bet” would be to place our chips on a place not yet so “staked out” toward one position of the other. The process of cannibalization and balkanization within medicine has been going on, largely unabated, for nearly 20 years. Why should the field of “anesthesia,” or any other area of medical practice, be immune to such pressures? Paul Starr, the Pulitzer Prize-winning writer and Harvard sociologist has put this conundrum more thoughtfully: “Who says doctors are best able to care for a patient?” A sobering question, indeed, and one we had better be able to answer, and answer well.

This is, then, the 21st century version of The Great Game—the battle over Mr. Starr’s sobering question. Disconcertingly, everyone has already assumed that, in fact, doctors may not be best qualified to hold such a coveted honor—and certainly the enormous and robust body of literature on quality of care supports this position. Add to this the fact that medicine has become a very timely political topic once again, and it becomes an unassailable fact that medical practice as doctors now understand it is destined for the footnotes section of some history text. Doctors need to internalize a fundamental truth—a truth that is driving politicians headfirst into a money-powered lust for power and prestige: whoever reaps the rewards and the gratitude and the good will offered by patients and their families in the course of their care will be the beneficiary of enormous power. Whoever pays for that care or provides that care will be blessed with the gratitude of an endless supply of voting citizens. Politicians know, *they know*, that to be an intermediary in the costs of sickness is a strategic role that confers social, economic, and political gains. And, like the Great Game for the oil in Central Asia, being such an intermediary in medicine is the one clear way to get to similar riches. Medicine is in play, and if we want to be involved, the time to ante up is now.

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