

THE SCHOOL OF MEDICINE  
OF  
THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL



MERRIMON LECTURE

*by*

ARNOLD S. RELMAN, M.D.

*October Nineteenth, Nineteen Hundred and Eighty-Two*

THE MERRIMON LECTURE

THE FUTURE OF MEDICAL PRACTICE

**ARNOLD S. RELMAN, M.D.**  
Editor, *New England Journal of Medicine*

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1982

### THE MERRIMON LECTURESHIP IN MEDICINE

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ARNOLD S. RELMAN, M.D.

ARNOLD SEYMOUR RELMAN was born in New York City on June 17, 1923. He attended Cornell University, graduating with distinction in Philosophy (AB, 1943). His medical education at Columbia University was completed in 1946, and he was both a member of Phi Beta Kappa while at Cornell and of Alpha Omega Alpha at Columbia. Dr. Relman's residency in internal medicine at Yale (1946-49) was followed by a series of important positions at Boston University School of Medicine. He arrived as a research fellow in 1949 and had progressed to a full professorship by 1961. He was particularly interested in water and electrolyte metabolism, serving as head of the renal and electrolyte section of the Department of Clinical Research. This general interest in the physiology of water and electrolytes, shared by many others including a large number in Chapel Hill, has metamorphosed into Nephrology, a clinical specialty which became firmly established—and lucrative—when renal dialysis became a responsibility of Medicare in 1972.

Dr. Relman was appointed Professor and Chairman of the Department of Medicine at the University of Pennsylvania in 1968, remaining there until he returned to Boston as Editor of the *New England Journal of Medicine* in 1977. His career has been punctuated at intervals by important lectureships at home and abroad—forty at last count—and he is the recipient of honorary degrees from the University of Pennsylvania, Brown University and the Medical College of Wisconsin. The high regard and trust in which he has been held are also indicated by past presidencies of the American Federation for Clinical Research and the American Society for Clinical Investigation ("Young Turks"), and by membership in the Association of American Physicians ("Old Turks," of which he is presently vice president), and the Institute of Medicine of the National Academy of Sciences. He is also a member of the Board of Directors of the Hastings Center of the Institute of Society, Ethics and the Life Sciences.

It is not difficult to argue that Dr. Relman is the most influential medical editor in America today. His editorial apprenticeship began with the important *Journal of Clinical Investigation* which he served as editor from 1962-67. He edited, together with Franz Ingelfinger and Maxwell Finland, a two volume series entitled "Controversy in Internal Medicine" (1966 and 1974). After the 10 year interlude in Philadelphia, he succeeded Franz Ingelfinger as editor of the *New England Journal of Medicine*, serving simultaneously as a Professor of Medicine at Harvard. He has skillfully utilized his position as editor of what is probably the most important medical journal in the world to help shape the direction in which medical affairs are moving, and has been particularly critical of certain proprietary aspects of patient care. Dr. Relman has long been interested in the future of medical practice, and it is because of his interest and his incisiveness that we have invited him to be the 1982 Merrimon Lecturer.

## THE FUTURE OF MEDICAL PRACTICE

My purpose in this lecture is to describe some of the major trends that are shaping health care and medical practice today, and to project those trends into the future. I hope thereby to provide clues to the probable condition of the medical profession in the years ahead, and to the problems physicians may be facing. I intend to demonstrate not only that the organization and delivery of medical care are changing rapidly, but that the ethos of the medical profession—its fundamental character and spirit—has been deeply affected by new economic and technologic forces. I will explain why I am particularly concerned about the expanding commercialism of health care today, and the growing tendency to blur the critical distinction between the medical profession and the medical care business. And, at the end of this talk, I hope to have persuaded you — especially the students and younger physicians among you — that these issues will need your serious attention if you want to preserve the humane traditions of your profession and see them survive into the next century.

### The Origins of American Medical Practice

To give some perspective, let me begin by describing very briefly the conditions of medical practice during the first three or four decades of this century, before it began to be transformed by the forces I want to discuss with you tonight.

The modern professional status of medicine in this country developed during the latter half of the last century and took final shape with the completion of the educational and licensing reforms that had been stimulated by the Flexner Report and spearheaded by the American Medical Association (AMA). By the early decades of this century, medicine was firmly established as the dominant and generally accepted health profession and it had the following characteristics. First, it was firmly rooted in the natural sciences, particularly biology and chemistry; second, it aspired to be rational and yet pragmatic, dependent on experience and the evidence; third, it was officially sanctioned and licensed by the state, but it was also largely self-regulated, self-credentialed and self-disciplined. (That, in essence, is the operating definition of a profession.) Most important of all for the purposes of this discussion, the practice of medicine was based on a special relation between doctor and patient, which is only briefly and inadequately described in the AMA's Code of Ethics, and has had surprisingly little written attention from any sector of organized medicine.

The essential features of that special relation are, first of all, that except in emergencies, a physician is free to choose whom he will serve. But once he accepts responsibility to serve a patient, the physician is obligated to act as the trustee for the patient's interest, whenever possible with the patient's informed consent. In serving as the patient's trustee, the physician is expected to apply generally accepted professional standards of care, always for the patient's benefit. The patient's interest takes precedence over all other considerations—certainly over any financial or other personal interests of the phy-

sician. The latest (1981) editions of the *Opinions and Reports* of the Judicial Council of the AMA is very firm and explicit on this last point. It says: "Under no circumstances may the physician place his own financial interest above the welfare of his patient. The prime objective of the medical profession is to render service to humanity. Reward of financial gain is a subordinate consideration." You will note that the Council does not say that financial gain is not *any* consideration. It merely says that such consideration should be subordinate to the patient's interests.

While the AMA's ethical code has never specified what form the physician's compensation should take, the assumption has always been, at least until recently, that the predominant mode would be fee-for-service. In accord with that assumption, the Council's *Opinions and Reports* have over the years devoted much attention to the subject of fees and fee-splitting.

Another important assumption in the early days was that patients would pay for their own medical care, *to the extent they could afford it*. This necessitated that fees be reasonable and commensurate with the patient's ability to pay. Indeed, most editions of the *Opinions and Reports*, until recently, contained a statement that said: "ability to pay should be considered in reducing fees; excessive fees are unethical."

We should recognize, however, that the fee-for-service arrangement, even when softened by charity, has always had an obvious and inherent conflict of interest for the physician. In economic terms, the fee-for-service physician is a supplier who is able to determine the demand for his own services. By virtue of his special knowledge, the authority vested in him by the state, and the trusting consent of his patient, the fee-for-service physician makes the decisions to use the medical services that he himself provides, and for which he will be paid on a piece-work basis. It is a situation with a built-in potential for abuse, and the possibilities have not been lost on some of the sharpest critics of our society.

George Bernard Shaw, for example, wrote a devastating satire of private fee-for-service practice in a *Preface on Doctors* which accompanies his play, *The Doctor's Dilemma*. He begins his Preface this way: "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, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid. Scandalized voices murmur that . . . operations are necessary. 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. If we did, no man's neck would be safe and no man's house stable. . ."

Shaw wrote that in 1911. Despite his misgivings, private fee-for-service practice survived in the United Kingdom for another 35 years before it was replaced by the National Health Service. In this country the private fee-for-service system has been more

endurable and more widely accepted. Until the past decade or two, it enjoyed the general confidence and support of the American public. There are many reasons for this. First of all, the behavior of most doctors was influenced by the ethical code of organized medicine, which clearly said that the whole system was based on the doctor's commitment to the patient's interest—the patient's interests were primary. Not only that, but it was unethical for the doctor to do anything that was unnecessary. Of course, the chance of a physician doing anything unnecessary wasn't very great in the days when there weren't many things for a physician to do beyond examining, counseling and comforting.

Except for a relatively few surgical specialists, most doctors, most of the time, had only their time and advice to offer. Until forty or fifty years ago, the great majority of doctors in practice in this country were primary care givers, who had only a modest and inexpensive array of procedures and remedies. When specialists were used, the referrals usually came from the primary care physician, so self-referral by specialists was not a problem. The major ethical concern in those days was fee-splitting between a referring physician and the specialist. But there weren't that many specialists around, and most medical care represented an on-going personal commitment by a primary care physician. The doctor usually had to live with the consequences of his medical decisions, as the patient did, because the doctor and the patient knew one another and the doctor acted with a sense of personal responsibility that usually restrained any tendency to promote his own financial interests.

Furthermore, one of the most important protections against conflict of interest is disclosure, and disclosure is built into the solo practice, fee-for-service system. The patient consulting his physician knows very well that if he chooses to follow the doctor's advice to have some test or procedure carried out, the doctor expects to receive a fee for the service. If the patient doesn't trust the integrity and judgment of his doctor, he can go to someone else, but there can be no deception about the nature of the arrangement because the physician's financial interest in the transaction is perfectly clear.

There was one final reason why the system worked pretty well. Until recently, doctors had more patients than they could handle. They really had no incentive to do more than was necessary for any patient because there were lots of patients out there and much work to do. As long as physicians were in relatively short supply, there was no pressure on them to offer their patients more than essential services.

### The Forces of Change

Beginning just before World War II, the system of medical practice in this country began to change; after the war, new social and technologic forces came into play that began to transform the profession and put new stresses on this simple satisfactory relationship between doctor and patient. One of the first and most important developments was the rise of specialism and an increase in the relative and absolute number of specialists. This, in turn, has led to the fragmentation of medical care and to less personal

commitment by physicians to patients. We have changed from a system that had over 70 percent primary care physicians to one that now has nearly 70 percent specialists, and from a system in which patients rarely consulted a specialist without advice and referral from their general practitioner or family physician, to one in which patients often refer themselves to specialists or are referred from one specialist to another—with *no* physician having responsibility for the coordination and continued follow-up of their total medical care.

Another major force that has changed the nature of the doctor-patient relation is the explosive development of new medical technology. The increasing technological sophistication of medical practice and the enormous growth of its scientific information base are, of course, both a cause and a consequence of the growth of specialism. There are now a vastly increased number of things that doctors can do for patients—many more tests, many more diagnostic and therapeutic procedures, and many more identifiable, billable items to be reimbursed by the third-party payers. Doctors are no longer simply offering their time and counsel. Each new specialty offers an elaborate a la carte menu of specialized services, and each item on the menu has a price tag. Even generalists have an office full of equipment and procedures which can be deployed to supplement the traditional services of primary care.

An article in the business section of the *New York Times* of October 12, 1982 illustrates the point. It is headlined: “New Tools in the M.D.’s Office,” and it tells how “The health-care industry, seeking new profits in a potentially lucrative market, is moving diagnostic testing out of the medical laboratory and into the doctor’s office.” It then goes on to explain how “a new generation of diagnostic equipment designed for use in a doctor’s office” is being developed and aggressively marketed with expectations of great profits for the companies manufacturing them. “Financial analysts say the new tests stand to increase the efficiency—and earnings—of doctors in private practice while improving patient care.” The trouble with this glowing assessment by the “financial analysts” is that the medical evidence to support the widespread adoption of many of these new tests in routine office practice is lacking. The same can be said about many of the technologies now being so widely used in hospital practice—and I am referring not just to new gadgets and diagnostic tests, but to the whole panoply of diagnostic and therapeutic procedures and special facilities that are applied in the practice of medicine.

I am not suggesting that physicians are inclined to use techniques known to be useless, or unsafe. Not at all: the vast majority of physicians want to use only the technology that they believe will benefit their patients. The problem is that many tests and procedures simply haven’t been adequately evaluated before they are used in practice and there often isn’t much reliable information about what is beneficial and what is not. New technology is being developed so rapidly, and there is such pressure to apply it in practice, as the article in the business section of the *New York Times* makes clear, that evaluation of safety and efficacy has lagged far behind. It is frequently much easier and more attractive to develop and introduce a new test or procedure than to carry out rigorous, well-controlled clinical trials to determine whether it is safe and effective.

Furthermore, even when a new medical technology has been adequately evaluated, it may be found to make only a small contribution to patient management, and the cost-benefit ratio may be dubious. Much medical decision-making therefore concerns the use of tests or procedures that either have not been adequately evaluated or are of only marginal value, thus leaving physicians to rely on their own judgment in deciding whether or not to apply them in a particular clinical situation. As the technology revolution expands, so does the degree of uncertainty and the role of individual discretion in the practice of medicine. Judgment has always been important in medical practice, of course, but the personal consequences for patients and the economic stakes for physicians are now higher than ever before.

Finally, no description of the post-war changes in medical practice can ignore what many observers consider the most crucial development of all, namely the rise of medical insurance and reimbursement by third parties. At the present time, around 85 percent of all patients in this country have some degree of third-party coverage—a system which up to now has reimbursed providers either for their charges or for some agreed upon schedule or fraction of their charges. Most third parties reimburse physicians on the basis of the so-called “usual and customary” (UCR) fee structure, a mechanism which gives incentives for the introduction of new specialists and new procedures.<sup>1</sup> With a fee scale that is primarily determined by the specialists themselves, the system rewards time spent doing procedures or tests far more generously than time spent examining, counseling or managing patients. The third-party reimbursement system also had an important effect on the behavior of patients. They became claimants for medical care to which they felt entitled because the insurance premiums had been paid, and they had no personal interest in what things cost, since they were not out of pocket. They therefore expected everything to be done that their doctor said needed to be done. The doctor, for his part, had no reason to be concerned about cost because he knew the insurance company would pay. And thus arose what the lawyers like to call the “moral hazard” of insurance: there was no professional or economic restraint on what was charged to insurance because of the view that it had already been paid for. But of course that kept driving up premiums, and contributed to the rise in health care costs, which is such a major national concern today.

The most influential third party payer is the federal government, which entered the scene in the mid-1960’s. At that time the concept of health as every citizen’s right was established and Medicare and Medicaid were passed into law. Expenditures in 1981 on these two programs alone amounted to more than 70 billion dollars, or approximately 25 percent of the total cost of personal health care in that year. With this massive government commitment came a decline in the concept of charity and in the doctor’s obligation to consider the patient’s ability to pay in determining his fees. It is not surprising, therefore, that in the latest edition of the *Opinions and Reports* of the AMA’s Judicial Council, there no longer appears any statement about excessive fees or the physician’s obligation to consider the patient’s ability to pay.

Lest I appear to be lamenting the disappearance of the good old days of the two-class system when doctors dispensed free care to the poor out of a sense of *noblesse oblige*, I

nt to make it clear that I consider Medicare and Medicaid to have been one of the  
or social advances of our time. You will note, however, that I use the past tense.  
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### The Rise of Commercialism

Health insurance and third-party payment, coupled with increased specialism and the  
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To illustrate what's happening in the practice of medicine today, I submit three  
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Another example is a personalized ad that a physician in White Plains, New York re-  
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said: "Dear Dr.: You probably recognize the value treadmill exercise testing and Hol-  
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will fit into your setting. What better way to evaluate the role of either or both of  
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which is to be held in Maui, Hawaii. For those who purchase equipment, the company  
offers to pay all expenses for two, for a week in a luxury hotel in Hawaii. They further  
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These examples could be multiplied many times over in the private practice of medi-  
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### Recent Developments

#### *Too Many Doctors*

In the last decade, new developments are compounding the problems I have been de-  
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want to make it clear that I consider Medicare and Medicaid to have been one of the major social advances of our time. You will note, however, that I use the past tense. New political policies in Washington and growing budgetary constraints in state and federal government are forcing cutbacks in these programs and moving us back towards the two-class system. Charity in the private sector may once again become the last resort for many of our indigent sick and disabled citizens. Nevertheless, the fact remains that most of our people do have some sort of health insurance, and this has powerfully contributed to the expansion of health care services in this country over the past several decades, and to the changes that I have been describing in the medical profession.

### The Rise of Commercialism

Health insurance and third-party payment, coupled with increased specialism and the technology explosion, have been largely responsible for the rapid rise in health care expenditures, and have created a new climate for medical practice in which there are virtually irresistible incentives for doctors to become entrepreneurial and profit-seeking in their behavior. It has become so easy to exploit the money-making possibilities of medical practice that economic incentives now play a far more important role in determining the behavior of many physicians. By simply doing more procedures and tests, most doctors can do very well for themselves—far better than ever before—even as they try to do good for their patients. The technology explosion has provided the tools and insurance has removed the financial restraints on their use that doctor or patient might have felt in earlier times. As legions of new sub-specialists graduate from training programs into this changed environment, they find it all too easy to take a fragmented, piece-work approach to practice, leading inevitably to the excessive or inappropriate use of established procedures and the uncritical use of unproven new ones. In this climate, the conflict of interest that has always been inherent in the fee-for-service system takes on larger and more disturbing dimensions, and the practice of medicine in many instances now begins to resemble a business enterprise almost as much as a profession.

To illustrate what's happening in the practice of medicine today, I submit three items that have come across my desk in the past year or two. The first is a flier sent to me by a physician in Missouri, which he had received from a midwestern counseling company. It read, in part: "If you have been searching for a practical and prudent way to reduce taxes and increase your income, here is an excellent opportunity to do so. During the last three years, individuals and corporations earning in excess of \$40,000 have purchased more than 1200 (blank) computerized ECG systems. A nationwide network of over 45 medical equipment distributors can place and service the system you purchase with other doctors in hospitals that actually use the equipment. The doctor or hospital using your equipment then pays you for each ECG they run, with a minimal monthly guarantee." Then the ad goes on to explain how the purchase and subsequent lease of this equipment provides a physician with depreciation, interest and expense deductions which can lead to large tax savings.

Another example is a personalized ad that a physician in White Plains, New York received from the Vice President for Marketing of a medical equipment corporation. It said: "Dear Dr.: You probably recognize the value treadmill exercise testing and Holter monitoring have in helping you deal more effectively with the epidemic incidence of coronary heart disease... but may have questions about the procedures and how they will fit into your setting. What better way to evaluate the role of either or both of these valuable procedures than to take advantage of this Special Offer..." The ad then explains that the company will pay the doctor's travel and lodging expenses to attend a 2-day professional educational seminar on exercise testing and Holter monitoring, which is to be held in Maui, Hawaii. For those who purchase equipment, the company offers to pay all expenses for two, for a week in a luxury hotel in Hawaii. They further offer to train the doctor's office staff and provide a 60-day period to evaluate the procedure on a lease or rental basis. They also offer to reimburse the doctor the difference between billings, and the rental during those 60 days. This kind of appeal evidently does not fall on deaf ears because the ad concludes this way: "We have assisted literally thousands of physicians to evaluate the role of these procedures in their setting. Let us send you referrals in your area."

These examples could be multiplied many times over in the private practice of medicine, but commercialism does not exist only among private practitioners; it is also to be found in the ivory tower. Many academic clinical departments depend to an increasing extent on income earned from fee-for-service practice by full-time salaried faculty, and some of them are also being affected by the entrepreneurial spirit. Not long ago I received a letter about a manuscript being submitted to the *New England Journal of Medicine* from the cardiology section of a well-known academic Department of Medicine. There was nothing unusual about the letter, but the letterhead caught my eye. Under the university seal and the names of the members of the cardiology section, emblazoned in large letters across the page was the following advertising information: "Cardiovascular Consultations, Diagnostic Ultrasound, Exercise Testing, Cardiac Rehabilitation, Intra-aortic Ballroom Pumping, Cardiac Catheterization." The only thing lacking was a price list for the services being advertised.

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the number of physicians will be 643,000, and GMENAC estimates that this will be 145,000 more than the country needs.<sup>2</sup> This rapidly expanding population of physicians is already increasing the competitive pressure on practitioners to generate more income by using marginal or new unproven procedures, tests and technology. As the numbers of physicians continue to increase, and as competition from outside the profession from nurse practitioners, chiropractors and other kinds of health practitioners also expands, the pressure is bound to grow.

#### *Competition and the FTC*

The second thing that has happened recently is a change in the government's attitude towards the practice of medicine. In 1975, in *Goldfarb v. Virginia State Bar*, the Supreme Court ruled that the professions are not exempt from the antitrust laws when they upheld a lower court's application of the Sherman Antitrust Act to the Virginia State Bar, which had attempted to establish and enforce a minimum fee schedule.<sup>3</sup> The Court said that this was price-fixing in restraint of trade, implying that under the Sherman Act, the legal profession (as well as the medical profession) was a trade, and that the government had a right to protect price competition. The Federal Trade Commission, which is the main regulatory body for enforcing the antitrust laws, has recently become especially interested in the medical profession, and has already instituted several actions against organized medicine, the most notable of which was a suit against the AMA to prevent it from prohibiting advertising by physicians. The AMA at the moment is lobbying for new legislation that would exempt professions from the regulatory authority of the FTC, but not from the jurisdiction of the anti-trust laws. The Administration seems to be encouraging commercialism in the practice of medicine, believing that price competition will help to hold down medical costs. The AMA, while hoping to escape from regulation by the FTC, does not seem inclined to make an issue of commercialism.

#### *Advertising*

In the meantime, there has been an increase in the use of commercial advertising by physicians. A particularly flamboyant example appeared in the *New York Times* of January 22, 1982. It was a full-page ad by a group of plastic surgeons in New York, called the "Creative Surgical Group." The ad had a bold headline that proclaimed: "You can do something about the way you look," and it featured some pretty slick copy. Here are a few samples: "Breasts can and should be beautiful. They needn't sag or balloon. What God did not give all women, we can. You would be amazed what an incredible difference it can make in a woman's attitude about herself. . . . Now your nose. Don't live with it if you don't think it's terrific. Noses are changeable. . . ." The advantages of face-lifts, otoplasties and hair transplants were also touted with equal enthusiasm. The ad then offered readers a booklet on "a thoughtful review of cosmetic surgery" for \$1.00, and ended with the reassurance that "all surgery is performed by Board-Certified plastic surgeons."

In discussing advertising by physicians, it is important to distinguish between the crassly commercial advertising of the kind I have just shown you and what might be

called informational advertising. The latter would be exemplified by a detailed professional directory, or by an announcement of the availability of medical services. Informational advertising in my opinion is perfectly consistent with the spirit of medical professionalism, but commercial advertising that seeks to promote the demand for services is not.<sup>4</sup>

#### *The New Medical Industrial Complex*

The third recent development, and I think perhaps the most significant of all, is the rise of what I have chosen to call the "new medical industrial complex." The purpose of this lecture is not to dwell on this subject, which I have discussed in detail elsewhere.<sup>5</sup> But no consideration of the new commercial spirit in medicine can ignore this extraordinary phenomenon. Over the past 10 or 15 years we have seen the rise of a new kind of health care industry. These are businesses, usually large investor-owned corporations, that own or manage hospitals, nursing homes, clinics and emergency rooms, HMO's, diagnostic laboratories, dialysis centers, and a large variety of services and facilities that were formerly provided almost entirely by voluntary or government not-for-profit institutions or by private physicians. It is a huge and rapidly growing industry. It virtually began from scratch in the decade of the 60's and now accounts for roughly 15-20 percent of the personal health care delivery system in this country, with a gross income of probably more than 40 billion dollars a year. This estimate does not include the pharmaceutical industry and the manufacturers of laboratory and hospital supplies and equipment.

The investor-owned hospital industry, which is one of the largest segments of the "new medical-industrial complex" is consolidating into a few very large corporations that are gobbling up all the little fellows. There are now about five giant hospital corporations which control almost two-thirds of the investor-owned hospital market, which comprises about 1000 general hospitals in this country today. Some of these companies have sales of over two or three billion dollars a year. They market their hospital services just the way any profit-making company would be expected to and they're encouraging doctors to use their services.

Some of these companies put ads in the medical journals, which in effect say to young doctors "Where in the country would you like to practice? Would you like to practice in sunny Arizona, or in beautiful Florida or California? We'll take care of you." Young physicians send in their credentials and practice preferences and the companies place them in a hospital that they own or manage. They will set a new doctor up in practice. They arrange loans and guarantee the first year's income; they may offer a rent-free office for a year: they buy equipment if necessary. And all the physician has to do is agree to practice in their hospital.

Doctors are being wooed as customers of the investor-owned hospitals. But doctors all over the country are also investing in these companies and in many cases they are taking an active entrepreneurial role—founding and managing all kinds of health care businesses such as nursing homes, diagnostic laboratories, dialysis units and so on. I don't know the exact extent to which this is happening—I doubt if anyone has accu-

rate data—but I have the impression that it is very common for doctors to be investing in these profitable businesses. In doing so, physicians compound the conflict of interest that has always existed in fee-for-service medical practice, and they do it in a way that does not allow for disclosure. When physicians have financial interests in businesses that make profits by marketing health services to patients, the role of the physician as the trustee for the patient is called into question. How can the public be expected to have confidence in the profession, and how can the profession retail its own image of dedication to the public interest when physicians become entrepreneurs in this way? It is a situation that challenges the character and spirit of the medical profession.

The key question is: Will medicine now become essentially a business, or will it remain a profession? Medical costs will have to be controlled; they are increasing to a degree that requires some sort of control. Will the medical profession do its share to help society solve the problem, or will it increasingly become part of the problem? Will we act as businessmen in a system that is becoming increasingly entrepreneurial, or will we choose to remain a profession, with all the obligations for self-regulation and protection of the public interest that this commitment implies? If we wish to remain as a profession we're going to have to deal with the problems I have been describing. This is not the place to discuss in detail what I think needs to be done, but I offer in brief outline seven suggestions for initiatives that would reassure the public and help restore the image of the medical profession as being responsive to the needs of the public and the interests of patients.

### **An Agenda for Responsible Professionalism**

In the first place, I think we should address the medical manpower problem in a more positive way to deal with the impending problem of physician overproduction. We will need to look not only at the physicians we're producing in the United States, but at the thousands who are being educated in fourth-rate "offshore" medical schools and coming back into the American system through the back door.<sup>6</sup> Most of all, we will have to address the problem of the imbalance between primary care physicians and specialists. Regardless of what one thinks about the absolute number of physicians needed in the future, there is a clear consensus among the experts that something should be done to increase the proportion of primary care physicians and this will require concerted action by all those responsible for graduate medical education.

Secondly, organized medicine, together with the third-party payers, should change the relative value scale for medical fees. Physicians will need to deal with the problem caused by our present policy of rewarding procedures, tests and technology far more generously than primary care. As long as the fees for procedures and specialized services are so exorbitantly higher than those for personal services, there is little chance that primary care will be successfully encouraged or that we will reverse the trend toward commercialism and excessive use of fragmented "a la carte" medical services.

Thirdly, organized medicine should be more active in controlling the quality of

health care in this country. To restore public and governmental confidence in the ability of the profession to regulate itself, organized medicine will have to take more vigorous action against quacks and frauds and impaired physicians. It's going to have to police itself more effectively than it has ever done before.

Fourth, the medical profession should push for a national program of technology assessment.<sup>7</sup> I do not know whether such a program should be based in government or the private sector, but there is urgent need for a new mechanism of funding clinical trials to evaluate health care procedures, and organized medicine should do its part in supporting constructive efforts in this direction. New clinical trials and new data are needed, not simply pronouncements by committees based on inadequate available information. Physicians should be lobbying for new funding mechanisms to pay for the gathering of new data. Provided that practitioners have access to the new data and modify their practices in accord with the new findings, such a program is bound not only to improve medical practice but to save large sums of money now being wasted on unnecessary, ineffective or unsafe procedures. Technology assessment and the proper uses of such information in medical decision-making should be given more attention in undergraduate and graduate medical education.

Fifth, we should support experiments with new forms of medical care organizations that give incentives to reduce unnecessary hospitalization and promote more efficient practice. Organized medicine should be more receptive to experiments like HMO's and primary care networks. All too often in the past, established professional groups have resisted such experiments, leading to the public impression that they were sometimes more concerned about their own economic interests than the public welfare.

Sixth, the medical profession should support improvement and rationalization of the hospital reimbursement system. We should support the prepayment approach to reimbursement of hospitals and encourage the institution of cost control incentives. But, as we move to a system of prospective reimbursement, one that gives the hospital an economic incentive to be more efficient and less expensive in its management of patients, the incentives for physicians for the first time may be in direct opposition to the incentives for hospitals.<sup>8</sup> It may be in the doctor's economic interest to have more money spent on hospitalization, whereas with prospective payment, hospitals may benefit from spending less. Physicians will have to face up to that problem and deal with it responsibly—not simply by setting up diagnostic and treatment facilities in their offices that will compete with the hospitals.

Finally, but perhaps even more important than any of the other points, the medical profession should publicly and clearly separate itself from the health care industry. It should declare as an article of its ethical code that doctors should derive income in health care only from their professional services and not from any kind of entrepreneurial interest in the health care industry. In my view that would be the best way to reaffirm the credibility of the medical profession and demonstrate its entitlement to a continuation of the implicit social contract that exists between medicine and the public.

The public gives doctors special advantages and privileges in exchange for a commitment to put the public's interests ahead of any personal economic gain. *Ipsa facto*, involvement of practicing physicians as investors or entrepreneurs in the "new medical-industrial complex" raises serious doubts about this commitment. Physicians should be fiduciaries or representatives for their patients in evaluating and selecting the services offered by the health care industry; they cannot ethically serve in that capacity if they also have financial interests in that industry.

### The Future: A Business or a Profession?

A commitment to these seven initiatives would, in my opinion, be clear evidence that the medical profession wishes to meet its public responsibilities as a profession and that it does not regard itself as simply a highly skilled business or trade. These initiatives are not the only, nor necessarily the best, ways to solve the problems I have outlined in this talk, but I believe they are a good way to begin. If we cling to our present course, I am convinced that the independence and ethical base of our profession will be progressively eroded and the practice of medicine will continue to evolve into commerce. The market-place will dominate: the Federal Trade Commission will become more active, and the medical profession will see more federal regulation. We may have trouble with the Federal Trade Commission in any event, whatever the medical profession does, but I believe that problem can be worked out if the medical profession is seen to be acting in the public interest. Failing that, there may well be a progressive weakening of the fee-for-service system. Already almost 50 percent of all physicians are salaried, even excluding house officers, almost 40 percent of physicians work for a salary.<sup>9</sup> In the absence of any kind of professional self-regulation, that percentage will continue to grow. Doctors will more and more become employees. Doctors' unions, which already have 40 or 50 thousand members, will become even more powerful. Doctors will ultimately function less as independent professionals and more as businessmen or employees in a commercial market.

The choice between this course and continuation as responsible, independent professionals, is in the hands of the profession, particularly the new physicians. Although the problems were generated by external social and economic forces and by inevitable technological changes, the predicament that I've described is basically an internal moral crisis. We have the means to solve our problems if we but choose to do so.

### REFERENCES

1. Roe BB. The UCR boondoggle. A death knell for private practice? *N Engl J Med.* 1981; 305:41-5.
2. U.S. Department of Health and Human Services. Report of the Graduate Medical Education National Advisory Committee. September, 1980.
3. 421 U.S. 773(1975).
4. Relman AS. Professional directories—but not commercial advertising—as a public service. *N Engl J Med.* 1978; 299:476-8.
5. Relman AS. The new medical-industrial complex. *N Engl J Med.* 1980; 303:963-70.
6. Relman AS. Americans studying medicine abroad: We need a new policy. *N Engl J Med.* 1978; 299: 1012-4.
7. Relman AS. Assessment of medical practices: A simple proposal. *N Engl J Med.* 1980; 303:153-4.
8. Iglehart JK. Health Policy Report. The new era or prospective payment for hospitals. *N Engl J Med.* 1982; 307:1288-92.
9. Kahn HS, Orris P. The emerging role of salaried physicians: An organizational proposal. *J Public Health Policy.* 1982; 3:284-92.