The Hazards of Harassing Doctors

Regulation and Reaction in Trans-Atlantic Healthcare

The New Vital Force in Health Care Policy

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Introduction

William Osler, generally regarded as the father of modern medicine wrote "If you listen carefully to the patient they will tell you the diagnosis." Arriving at a diagnosis and appropriate treatment plan has always represented collaboration between individual patients and their personal physician.

But today physicians are increasingly seeing the decisions that they and their individual patient reach about a specific treatment plan second guessed by distant “third parties” (working for government or insurance bureaucracies) who, of course do not –indeed cannot- know the physician or the unique individual circumstances of a particular patient. Lacking any knowledge of the patient or the doctor, these bureaucrats must fall back on general “guidelines” as the basis for approval or rejection of a particular treatment. Having served on guideline development bodies I can tell you that, at best, they represent the kind of “lowest common denominator” conclusions necessary to get the many different opinions represented on a committee to coalesce into a consensus. At worst guidelines represent a deliberate effort to drive down the cost of treatment by emphasizing “one size fits all” treatment approaches. While the physician-patient relationship theoretically remains the fulcrum of good medical practice and medical progress, in reality it is rapidly being replaced – on both sides of the Atlantic – by guidelines.

This movement towards guideline driven medicine to which access to healthcare and physician reimbursement is increasingly linked, is based on the assumption that variations in medical practice are not only wasteful, but also potentially dangerous. Eliminating variations in clinical practice, we are told, will increase quality and save billions that could be poured into covering more uninsured or increasing coverage. The key to standardizing treatments – and outcomes – therefore are guidelines based on a combination of retrospective analysis of randomized clinical trials and the results of large prospective studies that compare the cost and effectiveness of established treatments or drugs in certain disease areas.

I bring a special perspective to this subject because of my professional background. On the one hand I have been a practicing physician for nearly 40 years and during almost all of those 40 years I was medical researcher and policy maker at the National Institute of Mental Health (NIMH). Incidentally my long experience in a part time private practice came about as a consequence of government salaries at the time not being competitive with academia so that a private practice was allowed in order to retain talent.

I was director of NIMH during the health care reform efforts of the first Clinton administration and, as such, I participated in some high level meetings of groups that were part of the effort. It is now well known that the perspective of practicing physicians was not included in this health care reform effort and my involvement was as the government’s principal mental health official, not as a clinician. Indeed I doubt that any

of the other participants in the meetings I attended even knew that outside of my government job I was a physician in the private practice of a medical specialty.

I present this history so that the reader can understand what I am about to say. The meetings I attended had a surreal "Alice in Wonderland" quality. Here were all of these intelligent, well educated, well intended professionals discussing meta-analyses of controlled clinical trials, outcomes research, etc, etc, and yet it seemed that that none of them really understood what clinical practice was all about – it's about enormous individual differences even among patients with the same diagnosis, it's about cross-over trials where the physician uses each individual patient as their own control, trying treatment B when treatment A isn't working, etc, etc Today's advocates for coercive guideline driven medicine (as opposed to guidelines which are advisory to the doctor and the patient) seem to be cut from the same cloth as the people I encountered on those committees in the early 90s, except that now the lure of saving money and increasing the profits of managed care companies provides a new level of passion and intensity to these efforts.

The following essays by Alphonse Crespo, a Swiss physician and Mark Siegel, an American doctor resonate with my own efforts to integrate my experience in research and in health policy with day to day encounters with real patients. They reflect my growing conviction that cost driven standardization of care is at the expense of patient well being, innovation and quality care.

In Europe, doctors are limited by reimbursement patterns and practice guidelines designed to control costs. This trend is growing in the United States. Yet there is no evidence that limiting access based on reviews of clinical literature or large scales trials either improves outcomes or saves money. On the contrary, the outcomes evidence suggests that seeking to elimination variations in practice and prescribing is actually more costly and contributes to morbidity.

Studies that look at the association between restricting access to medicines on the basis of cost and outcomes have consistently shown that people are likely to wind sicker and costing more money. In seniors, such limitations can drive up the incidence of morbidity double fold. Certainly drug and diagnostic costs will decline, but at what price?

The practice guidelines themselves are not the problem, it is how they are applied and for what purpose. As I noted above, voluntary guidelines provide the intelligent physician with a benchmark from which to mark a patient's progress or the impact of prevention. I have been involved in the development of practice guidelines for the treatment of mental illness for nearly three decades. It is a given that by the time there are developed, the guidelines themselves are outdated as new clinical insights and biomedical discoveries inform and shape both diagnosis and prescribing. The rigid imposition of guidelines regarding what to prescribe and how to treat insure that doctors cannot tailor treatments to the patient or deliver the best care.

For instance, bureaucrats and policymakers, dismiss many new drugs as simply "me-too" variants of drugs already on the market. But many patients benefit from such variants. For example, those who refer to the variety of selective serotonin reuptake inhibitor (SSRI) antidepressants as simply "me too" drugs, must ignore medical literature showing that many patients who fail to improve with one SSRI do well with another SSRI. Practicing physicians encounter this all the time.

Further, what sense does it make to select elimination of cost variations by region or country when the goal of translational research is to take a deeper understanding of variation in response to treatment and apply it in ways to more effectively attack disease? The claim that “off-label” treatments are experimental and untested is so simplistic and utterly misleading that it would seem to require a wilful ignorance of even the most rudimentary understanding of how a particular use (indication) for a drugs get on its label. The AMA estimates that over 70% of medication use by specialists is “off label. Take lithium, It’s FDA label was written in the early 70’s at the time the drug was first approved for the treatment of bipolar disorder, and it’s never been changed. In other words, the lithium label is over 30 years old, entirely uninformed by everything we’ve learned about that drug over the last three decades. Almost by definition anything newly discovered about any drug once it goes generic will never get onto its label

What will guideline driven medicine do to innovation? It will gradually choke it off. Why? Because the history of medicine teaches us that many fundamentally new directions in treatment started with an individual physician trying something new –that is something that would not be approved by the existing guidelines. After the initial experiments by a physician in one or a few patients, then the research community moves in to separate the wheat from the chaff; but without the freedom of that individual doctor to try something unconventional, there would be nothing for the research community to confirm or reject.

Finally, the emphasis on cost-containment undermines continuity of care. The recognition that someone with mental illness is twice as likely to suffer from heart disease, diabetes or hypertension reveals the interaction of disease pathways which themselves have been show to be highly individualized. The evidence-based medicine movement fails to incorporate such insights. Rather, by emphasizing studies that evaluate the treatment of one aspect of a particular disease in a vacuum, the EBM movement is contributing to fragmentation of care.

Clinical decision-making is becoming increasingly centralized and the domains of economists or physicians who crunch numbers but never practice medicine. This paper underscores that to the extent the physician is under siege by such a movement, patients and medical progress are the ultimate casualties.

Frederick K. Goodwin, MD

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Dr. Goodwin is the former Director of the National Institute of Mental Health (NIMH), the largest research and research training institution in the world dedicated to the application of biological, behavioral, and social science to the treatment and prevention of mental illness and refinement of mental health services. Prior to that, he held a Presidential appointment as head of the Alcohol, Drug Abuse, and Mental Health Administration. A physician-scientist specializing in psychiatry and psychopharmacology

Dr. Goodwin served from 1981 to 1988 as NIMH Scientific Director and chief of Intramural Research. He joined the NIMH in 1965 and has become an internationally recognized authority in the research and treatment of major depression and manic-depressive illness. For example, he was first to report the antidepressant effects of lithium in a controlled study.

Dr. Goodwin is a recipient of the major research awards in his field including the Hofheimer Prize from the American Psychiatric Association, the International Anna-Monika Prize for Research in Depression, the Edward A. Strecker Award, the Lieber Prize from NARSAD, the McAlpin Award, the Distinguished Service Award from NAMI, and the Research Award from the American Foundation for Suicide Prevention. He was the first recipient of the Psychiatrist of the Year from Psychiatric Times, and the Fawcett Humanitarian Award of the NDMDA. In 1998 he was elected President of the Psychiatric Research Society.

The author of over 450 publications, Dr. Goodwin (with K. R. Jamison, Ph.D.) wrote Manic-Depressive Illness, the first psychiatric text to win the Best Medical Book award from the Association of American Publishers. He is one of five psychiatrists on the Current Contents list of the most frequently cited scientists in the world and one of twelve psychiatrists listed in The Best Doctors in the U.S

Uncle Sam, M.D.?

On both sides of the political aisle, presidential candidates have labeled universal health coverage as the moral challenge of the decade. But is a government-run health care system the best means to bring this about?

Well, that depends on whether you want your health insurance and medical services to be provided by the same folks who run the Department of Motor Vehicles and Federal Emergency Management Agency.

Look abroad and you'll see the disastrous effects of a government takeover of the health care industry.

In Canada, patients languish on surgical waiting lists for months. In the province of British Columbia, for example, more than 75,000 citizens were waiting for surgery at the end of September 2007. Even for serious procedures such as cardiac surgery, the average wait time is more than nine weeks.

In the single-payer health systems dotting Europe, price controls on prescription drugs have reduced the supply of treatments available to patients. Good news for the bean counters, but bad news for the sick.

What's more, price controls have caused an atrophy of the European pharmaceutical industry. Fifteen years ago, European firms were responsible for 80 percent of drugs invented worldwide; today, they account for less than 20 percent of new drugs.

So not only have European patients taken a hit, thanks to reduced availability of medicines, so has the European economy.

Such dirty secrets are why most advocates of universal health care harp exclusively on access to insurance, which everyone agrees is important. In doing so, they obscure these insidious aspects of a government-run system.

Among those who work full- time, for instance, the vast majority receive access to either a health maintenance organization or a preferred provider organization through their employer. Older Americans have Medicare, while Medicaid serves the poor. Active and former military personnel are in the insurance system run by the Department of Veterans Affairs. Self-employed people may acquire individual policies or exploit the benefits of high-deductible insurance policies and health savings accounts.

Even for the indigent, care is widely available — at either a heavily subsidized level or often for free. And it's illegal to turn a patient away from a hospital emergency room for lack of an insurance card.

Vaccinations are often free for children and the elderly, and free or low-cost walk-in clinics have grown in popularity throughout the country.

When it comes to prescription drugs, both manufacturers and retailers have set up programs to provide needed medicines to low-income patients at reduced cost.

What about the oft-cited 47 million Americans who “lack insurance?” Such a number sounds catastrophic, but an examination of the details reveals that such figures are not always what they seem.

First, included in that number are scores of healthy young people — close to 20 million, by some accounts — who elect not to buy health insurance even though they can afford it. They voluntarily choose not to have health insurance — which is quite different from not being able to get health insurance.

That figure also includes 10 million illegal aliens. None of the politicians currently touting his or her plan for universal coverage has addressed this significant portion of the uninsured pool. And if the government can’t identify who’s here illegally anyway, how can it possibly ensure that they’ve purchased health insurance too?

Finally, the 47-million statistic isn’t static. Most of those who are without insurance are only without it temporarily — as when switching jobs.

When we get down to brass tacks, it turns out that many politicians and media types have created a phoney verbal distinction between “universal health coverage” and “government-run health care.” Universal coverage is not possible without government coercion — and all the disastrous side effects that come along with it.

While it's nice having a doctor in the family -- it shouldn't be your Uncle Sam.

Our current system may be problematic. But the “free lunch” promised by advocates of government-run health care is anything but. Its costs are clear: price controls that stifle medical innovation, and a rationing of medical services that leaves many patients out in the cold while disempowering physicians.

And if you want to really understand what happens when you disintermediate the physician, I highly recommend you read the following two essays, the first by a Swiss physician (Dr. Alphonse Crespo) and the second by an American practitioner, Dr. Marc Siegel.

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The Hazards of Harassing Doctors

Regulation and Reaction in European Healthcare

by Alphonse Crespo MD [i]

Abstract

Third party interference ingrained in socialized healthcare sparks patterns of medical behaviour no longer centred on patient care. For decades, European doctors grudgingly adapted to the administrative constraints of social security processes. This is changing. The pressures on resources and the rationing of care that mark the decay of redistributive healthcare models now lead to gusts of regulatory measures that target essential features of medical autonomy. Current regulatory policies affect physicians' professional status, their relationship with patients and their efficiency. Bureaucratic interference with medical practice has reached a threshold that now pushes doctors to engage in protest movements in various parts of Europe. Physician strikes and demonstrations have so far tended to limit their scope to calls for better working conditions. They were generally conducted without full scrutiny of the causes of crisis in modern healthcare and rarely focused on the moral issues raised by regulatory action and reaction. Doctors have yet to make their voice heard in the battle of ideas that opposes the guardians of obsolescent socialized medicine and proponents of a free society. The outcome this battle will shape the fate of their patients and the future of their profession. They cannot afford to stand by and ignore it.

Introduction

Beyond its impact on the quality of care and on the invisible costs of illness, government tampering with doctor autonomy and patient choice raises crucial questions related to human liberty. Starting from an overview of physician autonomy in History, this paper examines some of the consequences of over-regulation of medical practice in Europe today with a focus on countries noted for a high level of medical service such as Switzerland, France and Germany. It outlines strategies to help physicians regain control of their art and recover their responsibility as leaders in the war against human suffering and disease.

I. Physicians and Authoritarianism in History

The fate of individuals who choose to devote themselves to the art of healing has varied greatly in the course of history. Some healers became saints or icons; others were burnt at the stake. The status of physicians in society intimately reflects perceptions and beliefs related to illness and disease at given times and places. The institutional architecture and social or legal frameworks produced by dominant creeds or ideologies also impinge on the outcome of their endeavours as healers. In his first aphorism, Hippocrates, the "father of medicine" overtly acknowledged this influence of "external circumstances" on successes or failures of the art.

The professed objectives of doctors, the knowledge that they are perceived as holding or that they duly acquire, compounded by the strong emotional impact of suffering and disease has naturally tended to put them in position of authority. Their power has seldom found itself in open conflict with that of rulers. The might inherent to medicine and that wielded by kings or presidents do not operate at the same levels and are of a different nature. Physicians however, have had to contend or to compromise with existing societal power structures often at the expense of the essence of their trade. The tragic history of totalitarianism in 20th century Europe shows how indiscriminate allegiance to state authority or to reigning ideologies can easily pervert medical power.

At the dawn of medicine, the power of primitive healers emerged from magic, superstition or religion. It seldom strayed far from that of kings or rulers who invariably draw their legitimacy from the same sources. In ancient Mesopotamia, all strata of society were ultimately subjected to the rule of the king. Certain categories of healers enjoyed the status of priests. Religious privileges partly shielded them from the monarch's authority. Others: in particular the street surgeons were answerable to arbitrary laws and decrees. The Hammurabi Code established fees for given procedures. It also set sentences for unsuccessful treatments; compensation was based on the *eye for an eye* principle with some exceptions: a doctor’s eye had less value than a nobleman’s tooth, while a doctor’s finger was worth more than a slave’s life. This heavily authoritarian environment produced little progress in the art of healing. Ailing Babylonians took to the custom described by Herodotus of shunning healers and exposing their ailments on the marketplace hoping that some passer-by who may once have suffered from the same symptoms might stop and give advice.

The scientific foundations and the ethical principles that have guided and enlightened medical progress throughout its history can be traced back to Ancient Greece. They were the product of a society that combined great intellectual liberty, a deep respect for reason and a strong marketplace. Greek physicians contracted directly with patients in an extremely competitive environment. They had to rely on good prognosis and on reputation rather than on protection from the state or from the gods to earn their living. If one looks at the history of medicine to this date one can see significant advances whenever physicians have practiced their trade without intrusion of religious or secular authority. When they relinquish professional autonomy for whatever cause, physicians forsake responsibility with effects on their ethical commitment and on the progress of their art.

As from the 19th Century, physicians have had to cope with ideologies that attempted to empty medicine of its market essence. Bismarckian and Marxist concepts on the omnipotent, omniscient and omnipresent functions of the state captured the medical trade with lasting consequences. The effects of socialist dialectics on medical minds are felt to this day. Modern doctors are not at ease with the thought of patients as consumers or illness as a market even though this notion was self evident to their predecessors, starting with Hippocrates. They fail to grasp the mechanisms of exchange and contract in a free society or the functions of price and profit (a Marxist sin). This has made physicians vulnerable whenever their earnings have been questioned or attacked by those who wished to socialize and subdue their profession.

Before laws did the rest, the whiplashes that drove the medical profession out of the market were not altogether undeserved. Collectivist ideologues lured and lulled the mainstream of the profession into seemingly secure state protected cartels or state enforced monopolies. Subtle perks and short-lived privileges bought the submissiveness of doctors, though there were instances when the goading was less tactful. Aneurin Bevan's celebrated “I shall stuff their mouths with gold!” at the inception of the NHS, still rings loudly in the ears of older British physicians yet left to wonder where the gold went. Alternatively pressures bedeviling profit as incompatible with their altruistic mission, inhibited doctors from openly striving for high revenues.

By yielding on incomes, European physicians forfeited economic power and gradually lost their grip on their tools. Doctors can no longer afford to purchase some of the heavy hardware that goes in par with modern health technology, let alone to own and run hospitals. Property means control. In the best of cases, professionals are able to partner with business investors or charitable foundations for the acquisition and management of heavy technical equipment, surgical facilities or hospitals. In most instances however doctors have allowed these to fall into the hands of government and its subsidized proxies. The interests of patients rarely conflict with those of physicians. The same cannot be said of government planners and regulators. Healthcare is but one among many conflicting priorities that modern policy-makers choose to tackle.

II. Downgrading Swiss Care by State Planning and Decree

Swiss social sickness insurance schemes rooted in 19th century constitutional reforms were designed for lower income groups and industrial workers. More affluent segments growingly came to insure through these funds. This trend added to changes in the age pyramid and advances in medical technology, brought financial strains on an intricate multi-tiered system that until the mid 20th Century had functioned with clockwork efficiency. Cost-containment and regulation of healthcare growingly became priority policy objectives and led to a revised sickness insurance law (LAMal) voted in 1994. Amongst other changes, basic health insurance was made compulsory. This enhanced the influence of sickness fund cartels and strengthened the regulatory power of healthcare federal policy offices with immediate effects on costs and quality. It also allowed strong-armed and in some cases unconstitutional measures to enter the game.

In 2002 federal government decreed a "clause of need" that suspended the opening of new private medical practices. This drastic measure that circumvents constitutional rights of doctors, stemmed from the assumption that rising costs were tied to an excessive number of practicing physicians. Any student of economics knows that in an unregulated market surplus offer brings prices down. It took five years for the Swiss Observatory of Healthcare to demonstrate that visits to doctors' offices were quantitatively unrelated to GP density. Errors in the statistical methodology of evaluation of doctor density have also come to light[1]. This may not stop parliament from extending the ban until 2010.

Fully trained doctors are now grounded in teaching hospital residency positions. This clogs post-graduate training pathways, disrupts specialization time lines and upsets the generational turnover of physicians. Recurrent institutional contempt for doctors also sends a message that dissuades upcoming generations of students from undertaking medical studies. The “plethora” of physicians pummelled by regulators in 2002 is giving way to a worrisome shortage that has made front-page news in 2007.

The restriction of private practices has also brought about a shift of primary care from generally cost-efficient doctor's offices to overloaded ambulatory services and emergency wards of costlier public hospitals. Here as in other experiments in government planning, deficits and scarcity inevitably come to haunt both the planners and the planned. Rationing and strife come next.

Switzerland shows no major differences with its neighbours with respect to number of acute hospital beds. It was second to Sweden in the ratio of nurses to hospital in-patients though the trend is changing: rationing nursing care is now part of the cost-containment picture in Swiss hospital and nursing home care. Between 1998 and 2000 the number of public hospital beds was hammered down by 6% through relentless mergers of regional

[1] Kocher G. Oggier W “Syseme de Santé Suisse 2007-2009” 2007,Hans Huber Editors, Bern ISBN 978-3-456-84453-4 p251-.254

hospitals, closure of acute care units, centralizing of heavier technology and slashing of nursing resources. [2]

The downgrading of regional hospitals has created inequities in access to specialized care and to state of the art medical technology. Patients from small towns or from alpine valleys are often bounced from one local hospital to another before they receive appropriate care. Ambulances (and even helicopters) have come to replace elevators as a routine means of transferring patients from one specialty unit to another. Waiting lists in University hospitals have increased. Increasing rates of critical incidents in larger hospitals, linked to medical errors, hospital infections and premature dismissals have been reported: patients in the Geneva and Lausanne University Hospital Centres are particularly at risk with a rate of over 40% of complications according to a recently published *Comparis*[3] study.

Recurrent public statements by respected medical academics reflect the concerns. Geneva and Lausanne University professors Guyot and Monnier denounce situations in which the indication for a surgical procedure "is decided by surgeon 1, the procedure is executed by surgeon 2 and the post operative follow up by surgeons 3 and 4" with subsequent dilution of responsibilities as is now current in the larger public hospitals. Excessive paperwork "phagocytes" the time of senior surgeons leaving little span for the proper supervision of residents in training. Dr Patrick Ruchat, the president of the Association of teaching physicians at the Vaud University Hospital Centre (one of the largest in Switzerland) adds: "We did not choose to do medicine to become millionaires but because we are inspired by an ideal of what good practice should be... The present trend deprives us of autonomous decision-making: this is affecting the sense of responsibility of physicians from the very out start of their training and is impacting on the quality of care." [4]

Discontent can take other forms. Substantial salary cuts of senior medical staff in major University public hospitals are leading to an academic "brain drain" as numbers of reputed specialists choose to leave the burdens and administrative hassles of teaching hospitals for the more rewarding private sector. The private hospital sector, open to citizens with supplementary insurance or to wealthy foreign patients offered 0.7 beds per 1000 population in 2000 (an increase of 17% from 1998) and is expanding at great velocity.

Only health planners were surprised by the predictable consequences of disconnecting hospital planning from reality and of pressuring doctors to whisk off care. In 2005, total sickness insurance expenditures reached the CHF 20 billion mark (a 5.6% increase from 2004). With a jump of 19.6%, outpatient care topped all other cost increases. Transferring of costs to the ambulatory sector of course has not stopped hospital in-patient costs from

[2] Schubert M. et al. Effects of Rationing in Nursing Care in Switzerland on Patients and Nurses' Outcomes: Basel Institute of Nursing Science, University of Basel 2004 (Unpublished report)
[3] "Comparatif des hôpitaux - Hôpitaux / Cliniques dans tous les cantons suisses" http://www.comparis.ch./krankenkassen/spitalfuehrer/patientenzufriedenheit-uebersicht.aspx
[4] "Le blues des chefs de service », 24 heures Daily, December 4 2997 page 23.

rising by 4.1% over the same time scale. Private practitioners' fees are now again on top of the regulators' hit list.

A new time-based fee system (Tarmed) brokered by federal health authorities was negotiated between the Swiss federation of doctors (FMH) and the sickness fund cartel. This fee scale introduced in 2004 was theoretically designed to upgrade the "intellectual activity" of doctors without increasing overall health care expenses. The "neutrality of costs" clause included in the deal implied drastic downgrading of fees for technical procedures. The new tariff so far has had no effects other than: a) surprised and often discontented patients now charged by the minute for "intellectual services" that inevitably include small talk b) longer waiting lists for operations, linked to disenchanted surgeons whose surgical fees no longer meet overheads c) befuddling billing processes that lead to uninterrupted haggling between doctors, doctor associations, hospitals and third party payers d) a thriving market for expert medical assessments necessary to solve administrative insurance questions or to clarify those related to litigation.

An extensive European survey on perceptions of trends in healthcare and their profession conducted in 2004, demonstrated that one Swiss doctor out of two sensed a decline in professional status over the last 10 years and that one out of three foresaw a decline both in his future role in the healthcare system and in his satisfaction with his practice. Only one out of ten doctors expected that his satisfaction and his status within the healthcare system would improve in the future. Close to 30% of Swiss doctors predicted that the quality of healthcare available to the average family was on the decline, while only 19% thought that it might improve.[5]

Swiss physicians have traditionally preferred compromise and consensus to conflict with authority. Regulatory harassment has changed this. The younger generations were the first to move with successful intern "pencil strikes" that paralyzed hospital administrative paperwork in various hospitals in 2002 and 2004. Their elders followed. Approximately 12'000 Swiss medical practitioners backed by a petition signed by 30'000 patients marched in the Swiss capital Bern in April 2006, in order to protest against the dismantlement of basic family doctor medicine and house-medical services.

Although health authorities pooh-poohed the protest, this event marks the end of consensus between medical professionals and political authority. Front-line doctors no longer accept health policy processes that have gnawed at their autonomy and downgraded their work for too long. They are awakening to the evidence that the governance of their profession can no longer be left in the hands of politicians and bureaucrats and that the time has come to reclaim leadership in decision making processes that directly affect their work and their relationship with patients. Physicians in other parts of Europe are coming to the same conclusions.

[5] Pfizer EUCAN survey: "Perceptions of Healthcare and the Medical Profession among European Doctors", Nov 1 2004 conducted by Consensus Research Group Inc, NY

III. French Tampering with Doctor Demography and Liberty

As is the case with other countries bordering Germany, the French health care system is based on the Bismarckian model of compulsory social insurance. French social security is complemented by voluntary health insurance (subscribed by 91% of citizens) designed to cover a large part of co-payments. Primary outpatient care is mostly provided by general practitioners or by specialists in private practices. Until 2005 patients were free to choose any registered provider outside hospital: they now have to see a provider that acts as gatekeeper before consulting any other doctor if they want to ensure full reimbursement for the service. A referral is also necessary for them to consult a specialist outside hospitals.

French doctors have traditionally enjoyed a large degree of freedom of prescription even though they were theoretically exposed to financial penalties if they grossly failed to abide by practice guidelines. A new contractual agreement (*Accord de bon usage de soins* or AcBUS) has refined these guidelines and has notably introduced prescription rules for a certain number of chronic conditions. Upcoming reforms are likely to increase the constraints on doctor autonomy. Administrative evaluation of all office based salaried and hospital-based physicians has become mandatory at a national level since 2004. Failure to adhere may lead to a withdrawal of doctors' licence to practice.

In France, doctors as other professionals are still free to settle their business wherever they choose. Disparities in the distribution of specialists exist as in other countries. Regional doctor density varies from 1 to 2.2 for specialists: Paris and the southern regions benefiting from a higher supply of doctors than Northern France. In spite of these regional variations, the French are generally satisfied with the availability of health services as various studies demonstrate. The European Health Consumer index, for example, ranks the French healthcare model above Switzerland and Germany with respect to medical consumer satisfaction. France also generally does well in international performance ratings based on health indicators. It was notably ranked number one in the world by the WHO in the year 2000. As noted by the European Observatory on Health Systems and Policies[6], the substantial levels of patient and public satisfaction with their system was largely due to "the availability of a plentiful supply of providers (and) a high degree of freedom for physicians and patients…"

Current regulatory policies aimed at doctor demography are changing this state of affairs. As in other European countries, control of doctor density has been a major regulatory objective of French health policy for the last twenty years. Restriction of entry into medical schools through a *numerus clausus* at the end of the 1970's was one of the first steps taken in that direction. Financial incentives to drive doctors to early retirement followed in 1988 and were reinforced in 1996. These measures have had some impact on doctor density (3.3 per 1000 habitants in 2000 France versus 3.9 per 1000 European Union average). More substantial decreases in the number of practising doctors are

[6] European Observatory on Health Systems and Policies – Policy brief "Health care outside hospital. Assessing generalist and specialist care in eight countries Pp37-48

expected within the next few years. A general shortage of anaesthesiologists and obstetricians is already causing concern. Northern France as well as less attractive rural areas across the country are feeling the pinch and now call for more practitioners.

Recent attempts to goad physicians into low-density areas through tax exemptions and other fiscal incentives put pressure on the tax scales of competing local municipalities without yielding the expected results. Regulation of doctor demography is also taking new twists as Frances' new government discussed coercing doctors into rural practice. This has caused wide uproar. Massive doctor demonstrations led Nicolas Sarkozy's ministers to tone down their rhetoric. Pledges were made that principles of liberty of practice would not be affected by recent social security legislation (articles 32, 32bis and 33) on doctor demography.

As elsewhere, protest actions of the younger generations of doctors were spectacular and ultimately proved effective. This is not surprising. Putting aside the energy inherent to youthful revolt it is indeed the young doctors that will be the most affected by obtrusive regulation governing medical practice. Established doctors are less concerned: any regulation that restricts the opening of new offices tends to protect them from the competition of newcomers. This inevitably creates tensions between generations as has been witnessed in Switzerland with rifts between active medical intern groups and strikingly passive established cantonal or federal medical associations who offered only token resistance to government restrictions.

Barriers to professional freedom of movement within French or Swiss boundaries also circumvent current European agreements on the free circulation of healthcare professionals. Hidden protectionist agendas within national doctor organizations probably contribute to their tolerance of local legislation that beyond teaching their younger colleagues patience, also dissuades foreign graduates from flocking into their fragile healthcare turfs.

The French have so far enjoyed a large measure of choice in healthcare. They partly owe this to supplementary private insurance that opens access to a thriving private hospital sector. Current cost-containment policies linked to administrative "coordination of care" are gradually eroding patients' liberty of choice. Diagnosis related reimbursement of hospital care introduced in 2004 is also creating problems linked to hasty *in and out* hospital care and the frequent complications that go with insufficient monitoring and inadequate bed rest after procedures. Hospital practitioners' work now hinges on an uncomfortable razors' edge: prudence exposes them to administrative sanctions while complications send them to law courts.

In France as in the rest of Europe, the medical corporation naively allowed itself to be trapped into 20th century bureaucratic temples. Save from the celebrated Belgian doctor strikes in the 1960s, physicians have lacked the time, the stamina or simply the courage to resist, let alone to reclaim their independence. The picture is beginning to change. In the past three years, doctors have not only demonstrated in traditionally vocal Latin

countries such as Spain France or Italy; placid and generally disciplined nations such as Switzerland or Germany are now faced with the phenomenon.

IV. Mutiny in Germany and Beyond

Post war Germany harboured Bismarckian social insurance in the West and Sovietized medicine in the East for nearly half a century. With reunification East Germans dispatched Marxism into the dustbin of History and embraced free world capitalism. Healthcare in Germany today however still reflects old Prussia's blueprint for regimentation of civil society.

German statutory health insurance dates back to 1883. It is based on the pay as you go principle and is built upon sickness funds and work related insurance schemes. Conflicts between sickness funds and practicing physicians were frequent at the inception of the system. The Leipzig Union founded in 1900 by a group of 21 doctors rose to represent 75% of German physicians by 1910 and was one of the major instruments of physician resistance to bureaucratic forces. Until 1933, physicians were able to successfully defend their autonomy through strikes and lobbying.

The German social insurance system was consolidated by the Nazis as was the regulatory power of the State. Access to services was denied to the Jewish population while medicine was used as another tool for the eugenic “cleansing of the Aryan race”. A number of physicians abandoned their Hippocratic commitments in favour of state dogma and played an active role in the implementation of the abject exterminatory policies of the regime. Some were condemned to death at the Nuremberg war-crime trials after the World War II.

Health policy in reunified Germany is strongly influenced by European Union recommendations. The decision-making powers of Statutory Health Insurance bodies have increased, as has state supervision. Conversely physicians’ autonomy has decreased in favour of that of the sickness funds. This has not gone without strife.

Medical strikes and demonstrations took Germany by surprise in 2005. Protests such as the National protest day in Köln on Nov 9th 2005 targeted bureaucratic hassles and extra paper work linked to the introduction of diagnosis related groups and of "quality assurance" models that take time away from medical treatment. Increase in administrative workload came in hand with a decrease in real salaries. Strike action was repeated in 2006 when 70,000 professionals demanded shorter working hours, better conditions and higher pay, blocking non emergency operations and procedures in 700 German hospitals and clinics.

Obsession with cost-containment has brought about regulatory measures that significantly affect the independence of German doctors. The “Drugs Saving Package” voted by the German parliament, introduces penalties for prescription of “expensive” drugs and rewards physicians who restrict their prescriptions to low-cost copy generics.

This ethically objectionable legal gimmickry - akin to bribing physicians not to treat to the best of their ability - was one of the sparks of the doctor protest movement. A recent survey suggests that 65% of German physicians condemn bureaucratic tampering with prescriptions.[7] Public perceptions echo their concerns. Questioned on this issue, 60% of people at large reckon that they will no longer get the best possible treatment from their doctors.[8] Judging by media coverage, most Germans sympathize with their doctors' plight but express scepticism as to their ability to influence government health care policy and budgeting.

Central planning of doctor demography took momentum in Germany as from 1993. Directives stemming from a *Social Code Book* stipulated that new practices may not be opened in areas where the supply of doctors exceeded 110% of the average number for a given specialty. Regulation is implemented in line with a set of 10 predetermined groups of planning areas. This segmentation does not take into account parameters such as average population age, gender, morbidity or supply of hospital beds in a given zone. In 2003 opening of new surgical practices was forbidden in 97% of a total of 406 planning areas! Dermatology and paediatrics followed suit with 91% of forbidden areas. With an average of 3.4 physicians per 1000 population Germany presently ranks below the European average.[9]

This deliberate constriction of number of doctors has repercussions on the average time they can spend with patients: 65% of German doctors spend 10 minutes or less with each patient. In comparison, in Belgium where government interference with doctor demography is tamer 86 % of doctors spend at least 15 minutes with each patient and 51 % more than 20 minutes. Belgians are satisfied with this and surveys demonstrate that 100% of citizens questioned believe that government has no place in regulating doctor's daily activity. The French show the same reticence: 98% of those surveyed also favoured a "hands off" policy in this respect. In Germany, 40% of citizens questioned are dissatisfied and would prefer that government regulated doctors' daily working hours. [10]

Doctor strikes have also hit other European countries. The Netherlands witnessed the first mass protest of doctors in the history of the country when one thousand family doctors demonstrated in front of parliament in The Hague in October 2000. Expanding demands for primary treatment linked to demographic changes and to longer waiting times for hospital care resulted in up to 70 hour per week workloads that Dutch doctors were no longer prepared to bear. The same year, 15'000 Israeli doctors stopped work for over four months: approximately 30'000 operations were postponed and more than three hundred thousand appointments were cancelled until state authorities granted their demands on condition that the doctors commit themselves not to strike again for the next ten years. Spain faced a national doctor strike in the spring of 2007. Amongst other claims, physicians called for an increase of their average consultation time from 8

[7] "Consensus Research Group Inc." Report of Findings: Doctors Perception of Health Care and the Medical Profession – Germany 2006", Research Conducted for the Pfizer Medical Partnerships initiative.

[8] TNS Health Care, public Survey for *Janssen Cilag*, February 2006

[9] Busse R., Riesberg A. "Health Care systems in Transition - Germany" WHO European Observatory on Health Systems and Policies, 2004.

[10] Miglani R, "Doctors Perceptions of Healthcare and the medical profession" 2006 Medical Partnerships Initiative

minutes to 10 minutes! Despite salary increases, that were partly granted after their action further protests are planned to obtain lesser weekly working hours. The epidemic spread to the Czech Republic. After repeated warning of the dangers incurred by patients from overworked doctors, Czech physicians went on strike in September 2007 to make their point heard by health authorities. In Italy, five million appointments and 45,000 surgical procedures were postponed on October 26th this year when doctors staged a 24-hour strike over short-term employment contracts. The strike that was initiated by 12,000 disgruntled doctors ultimately rallied 135,000 medical and non-medical staff.

Although one can understand the frustrations that lead physicians to abandon their patients for strike action, such action is clearly foreign to the medical tradition. Doctor strikes and demonstrations would be inconceivable if doctors and patients directly contracted for service without intrusion from third parties in a free healthcare market. As things stand today however, doctors have little choice. If he wants to cure his patients the modern physician can no longer limit himself to treating the ills that directly befall on the human body. Beyond bacteria, viruses or malignant cells he must also learn to diagnose and combat pathologic over-regulation and bureaucratic proliferation that impair his mission as a healer and imperil his patients.

Beyond spectacular union actions, some physicians are organizing outside their lame-duck professional associations in order to defend their interests and those of their patients. They no longer hesitate to learn from liberty minded professionals from other disciplines engaged in similar battles. Some join forces with individual patients in epic David vs. Goliath combats: the resounding victory of Dr Jacques Chaoulli who teamed with a patient to question the constitutional legitimacy of Quebec's outrageous legal ban of private Hospitals, shows how such battles are won.[11]

V. The Road to Empowerment

The 20th Century has taught us that experiments in central planning and regulation of economic activity inexorably end up in scarcity and rationing. Medical activity is no exception. As impelling as the reasons for government interference with medical services might seem, they are as harmful there as in other fields of human action. When healthcare professionals are deprived of autonomy, they are simultaneously deprived of accountability. They cease to work with optimal commitment and efficiency. Sterile administrative paperwork and recurrent conflicts with administrations distract their attention, their time and their energy from patients. Absurd regulatory policies such as those that target doctor density compounded by a general downgrading of working conditions and of social status foster a scarcity of physicians that has already started hitting patients hard in many parts of Europe. Waiting lists, overt or occult rationing in healthcare, overworked nurses and physicians, hinder the treatment and cure of disease. This ultimately increases the global costs of illness both in terms of wasted resources as in that of human suffering.

[11] Jacques Chaoulli, M.D "The Long Road to Freedom in Canadian Medicine" Journal of American Physicians and Surgeons Volume 10 Number 3 Fall 2005

By allowing a market economy to develop without excessive interference in other sectors of the economy countries such as Switzerland, Germany or France reap enough prosperity to sustain the hidden costs of regulated healthcare. Even in affluent countries however, Bismarckian models systems are running out of moral fuel, as was the case with their dead Marxist cousins. The dynamics of social change, boosted by demographic pressures on welfare expenditures together with rising public awareness of government impotence and inefficiency, will sooner or later lead to the devolution of socialized healthcare to a market economy, as was the case for other public industries and services. Perceptions on the role of government in healthcare are indeed changing rapidly. In Switzerland 69 % of citizens polled in 2006 called for more market in healthcare. The decaying British NHS remains a sacred cow, yet not more than 4% of those surveyed in an OFCOM Study in 2005 still believed that government has an important role to play in the improvement of healthcare.

A better understanding of the market by doctors is needed for a confident transition of their corporation to liberty in healthcare. The complexity of medical apprenticeship and the wide range of challenges inherent to everyday practice have caused physicians to neglect the study of the institutional framework and economical environment that shape and condition their professional activity. Prolonged exposure to ideologies and to social security models inherited from the 19th Century, has led them to condone regulatory policies that constrict care and hamper cure. Flawed perceptions of the role and value of health industry in a dynamic economy and insufficient knowledge of basic economics have impeded them from fully supporting free market reforms of healthcare.

Beleaguered medical professionals who understand that liberty is essential to the practice of proper medicine will avoid frustrations if they take their cause beyond the narrow scope of professional politics. They must learn to develop and strengthen partnerships with natural allies in other health professions or industries. Doctors are not alone. They will also gain efficiency and audience if they share their specific expertise with existing think tanks and institutes that work towards more liberty in society.

Enlightened health-policy makers can minimize the transition costs of change by deregulation of health insurance services, gradual privatization of public healthcare infrastructures and fiscal incentives for medical savings accounts and health banking capital. Devolution of autonomy and responsibility to healthcare is a pivotal element of this agenda: physicians have a duty to make their voices and that of their patients heard in the debate. Adequate knowledge of market dynamics together with an intimate understanding of why and how liberty will ultimately improve healthcare services for all, are prerequisites for a smooth move towards market reforms. Free market institutes have an important educational role to play in this respect.

Conclusion

Collectivist thinking has not only impaired quality care, technical innovation and therapeutic progress. It has also constrained liberties of patients, of doctors and of citizens at large. As central planning of doctor demography or of hospital networks demonstrate, some regulatory policies blatantly circumvent constitutional guarantees that protect entrepreneurial liberties, rights of establishing practice and even the life of citizens. By restricting patient's access to care or coercively limiting doctors' choices, policy makers shift legal paradigms in a direction that scorns essential liberties. Doctors at large have indeed become aware that by accepting regulation of medical care, they have become party to a rationing process that harms their patients. They have yet to fully realize that they are dragged by the same token into a discriminatory system of justice targeted at their own profession. If unopposed, this process will deprive them of fundamental freedoms.

THE VIRTUAL HOUSE CALL

By Marc Siegel MD

The Oath of Maimonides

"The eternal providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all time; may neither avarice nor miserliness, nor thirst for glory deceive me and make me forgetful of my lofty aim of doing good to Thy children.

May I never see in the patient anything but a fellow creature in pain.

Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements.

Today he can discover his errors of yesterday and tomorrow he can obtain a new light on what he thinks himself sure of today. Oh, God, Thou has appointed me to watch over the life and death of Thy creatures; here am I ready for my vocation and now I turn unto my calling."

ARE WE STILL THE BEST AND THE BRIGHTEST?

My father, Bernard Leon Siegel, is 84 years old. To look at his bulging waistline and to hear about his long-time history of heart disease is to wonder how it is that he is still alive. I can't prove it to you, but I believe that at least part of this answer lies with the cholesterol-lowering Lipitor (atorvastatin), daily aspirin, the beta blocker which lowers his blood pressure and relaxes his heart, and a cardiologist who is both gentle and firm and knows my father's idiosyncrasies as well as how hard to push him. When Bernie discovered he had diabetes and might need medication, this doctor, Dr. Martin Kahn, the same physician who was quick to start his Lipitor and aspirin now told him to try adjusting his diet.

I was nonplussed. My father had always said that Kahn was resigned to the big stomach, resigned to my dad's poor diet, yet now he was pushing Bernie to change it.

It turned out that Kahn knew something about my dad that I didn't. 50 years before, my father had quit smoking abruptly without any aids, with just the knowledge that cigarettes had led him to one too many cases of bronchitis. Kahn was counting on the same kind of reaction now. Bernie finally had incentive to lose weight. He had the strong willpower to do it if he had the reason.

Two months later my father had dropped 30 pounds and his glucoses were well under control without any pills. He had seen a top diabetes expert and was adhering to the strict

diet that his nutritionist had devised. The approach that had worked on my father would not work on most other patients. It required a knowledge and intuition of how Bernie's own particular willpower could work both for and against him.

Consider that this kind of stubbornness is a family trait that is probably identifiable on one of Bernie's genes. As genetic expression becomes even better understood, and we acquire more genetic tools to modulate genetic expression, the more we will need the kind of doctors who can manage this information with intuition and judgment on a case by case basis.

This observation may be counterintuitive – one would think that the greater the technology the less the need for an effective management. But real world medicine turns out to be just the opposite. In a technical age, applying bottom line thinking and an overzealous application of evidence-based medicine obscures the differences among us that the new technology is capable of revealing. Not only don't we all suffer from the same diseases, we are not all susceptible to the same diseases and we don't all respond equally to the same treatments. This may seem obvious, but the growing knowledge of how and when each of us will get sick or well mandates a greater skill set and commitment needed in our doctors to effectively treat us as patients.

It turns out the more arrows we have in our medical quiver, the greater the choices a doctor has to make, the greater the skill and judgment it requires to make them.

Unfortunately, this need for medical superstars comes at a time when medicine is moving further in the direction of shrinking reimbursements and insurance company-controlled strategies which put a stranglehold on a doctor's decision-making.

From the treatment of HIV disease to the treatment of diabetes to the treatment of acid reflux disease, new drugs have reduced suffering and improved the quality and length of life all over the world. Rather than receive credit for this, drug companies are often the target of media blame whenever an unanticipated side effect becomes publicly known. The biotechnology industry has created enzyme cures for deadly neuromuscular diseases, from Gaucher's to Pompe's, and has made exciting advances in the area of genetic research that are beginning to have applications for cancer. In 10 years we may be able to keep cancer from occurring by modulating an aberrant gene in those most susceptible.

But managed care insurance companies are pushing doctors to blindly follow their protocols and formularies, which increasingly means substituting generic alternatives for drugs that are already working, risking ineffectiveness as well as unanticipated side effects. The drugs I am being pressured to change to are not identical generic chemicals; they are similar but different chemicals in the same general class. Personalized medicine may seem to be more expensive, but is actually better suited to prevention and so may save money in the long run.

Here is an example: It had taken me several years to convince my patient Roger to take Lipitor. Although he didn't have known heart disease, his family history (his father had

died of it at 55) and high cholesterol made it seem likely to me that his coronary arteries were already clogging up with plaque. He had begun to exercise two to three times a week, and he insisted he was improving his diet, eating less meat and dairy, and more vegetables, fish and fruit.

Nevertheless, his cholesterol numbers continued to climb. When his bad cholesterol (LDL) reached 155, he finally agreed to take a medicine to lower it. Multiple studies had shown Lipitor's effectiveness at stabilizing coronary plaque and reducing heart attacks and strokes in patients with heart disease, so I started him on that.

In the past, Roger had tended to be intolerant of medications. He had occasional upper respiratory infections, for which I would prescribe antibiotics. But because he often developed diarrhea and fatigue, he would sometimes stop the pills in the middle of the course. He also suffered from gastric reflux disease, but reported that stomach medicines made him nauseated. I was nervous when he started Lipitor, but to my amazement, the days went by and he didn't call to complain.

Any muscle aches? I asked him when he returned to my office for blood tests, half expecting him to say yes. No, he said. In fact Roger had no complaints at all, and his blood tests showed normal muscle and liver enzymes, not to mention a dramatic lowering of his cholesterol.

I was careful not to interpret Roger’s success as a blanket endorsement of the minimal side effects of this drug. In fact, I’d had many patients who had complained of muscle soreness or cramping, with or without the associated elevation in muscle enzyme (CPK). This was personalized medicine at work – it would have been impossible to predict Roger’s response to the drug based on its side effect profile or even the sensitivity he had shown to other drugs.

Roger was happy until the day a year ago that his insurance company decided it would no longer cover Lipitor. It suggested simvastatin instead, a new generic version of the cholesterol drug Zocor, another popular statin. Simvastatin hadn't fared quite as dramatically as Lipitor in studies, but it was a reasonable alternative and was generally well tolerated.

But it absolutely made no sense to me to change from a drug that was likely more effective and was being tolerated to one that was unknown. I told this to Roger and offered to write a letter of protest to the insurance company, but surprisingly, he agreed to give the simvastatin a try.

A week later he was back with cramping muscle pain in his legs and arms. His CPK enzyme was elevated and I told Roger that I was going to change him back to Lipitor. But now he was afraid to take *any* cholesterol drug, and it took me several weeks to convince him to give Lipitor another try.

At this point I almost didn't need to write a prescription because my sample closet was filling up with Lipitor samples. It was obvious that this was Pfizer's response to the new threat that the generic simvastatin posed to the blockbuster drug's share of the market. (Drug samples arrive more frequently when a drug company fears new competition.) I set aside a three-month's supply for Roger, and when he next came to see me, without a word. I handed him the drug in a small plastic bag.

Everyone likes a freebie, and it was this gesture that convinced Roger to start taking the drug again. I was afraid that he would feel muscle aches just from the memory of taking simvastatin, but he didn't. Again he tolerated Lipitor well, and I was able to convince the insurance company to cover it by the time his copious samples ran out. Roger, a carpenter, could never have afforded to pay for the drug himself. The managed care company agreed to cover the drug when I threatened to go public with the story if they didn't. (I am writing the story anyway, but I am not mentioning the insurance company by name, though it could be almost any one of them).

It was clear that Roger's case didn't represent cost-effective medical care. Pushing generic drugs all the time doesn't make sense, especially when the drug being replaced is working and well tolerated.

Medicine is never a simple equation, and Rogers case is another example of how the art of medicine must be applied carefully - one patient at a time.

America still has the resources to accomplish this – we still have many of the best medical centers and best doctors in the world, even if our system no longer routinely supports the notion of quality over quantity. Tuition and loan payments are greater and greater and doctors are under increasing pressures to make more money at a time when reimbursements continue to shrink. Today's spiralling-expense technologically-oriented medical climate supports business-minded proceduralists who figure out a way to keep their practices profitable by reducing their time and effort while providing minimal care. Yet despite this managed care driven trend, many of our doctors are still too well trained and have too much pride and integrity to relinquish their essential roles.

It is difficult to be a healer and a businessman at the same time. Patients need passionate advocates rather than businessmen among their physicians, especially at a time when the technology itself is easily alienating. With the continuing advances in genetics, for example, we will have a growing ability to personalize medicine. We should not be diminishing our ability to do so by depersonalizing and marginalizing our roles as physicians. Unfortunately, the best way to make a profit is to provide a minimum of care. Insurance companies keep reducing the bottom line.

The contemporary model encourages doctors to spend less and less time with their patients and deliver less of their essence and be paid less for it. This model destroys quality medical care. I for one do not believe in this kind of bottom-line medicine. A physician should care about his or her patients and take pride in the treatments he or she delivers. Would you accept it if your children's teachers said they were no longer being

paid enough to update you on how your kids were doing? Dismissive uncaring teachers can provoke parents to transfer their kids to another school.

And a doctor doesn't have the right to assert he's going to do a crummy job just because he's no longer being paid what he thinks he's entitled to. Being a physician is still a great privilege. We see inside our patients both physically and emotionally. We are honored by our patient's secrets. This is how we should approach our profession – not, you've used up $50 of my time now get out of here.

But, we rely on technology to guide us more and more. Perhaps we go to the scanner too soon and too often. The art of careful listening is still at the core of good medicine. – With the latest genetics we can determine who is predisposed to a certain illness. Walking through a microbe-infested room, one of us may get sick and another not – why? Why does one of my patients get colon or breast cancer, another one not? We soon are able to figure out our worst diseases in advance of actually getting them, and then manipulate our genes so that we don't get them. Doctoring may be combined with technology in a way that helps us go patient by patient to discover the answer. This consummate approach is hard to combine with the $40 visit. Imagine your doctor saying, "I'm sorry, sir, but if I got four times this fee only then would I be able to talk about genetics."

Our health care system in the U.S. has come under widespread attack for not providing uniformly excellent care for all Americans, but critics too easily overlook the crucial issue of quality and exactly how to preserve it.

In this bottom-line climate which promotes mediocre health care in the U.S., it is no surprise that some people are looking outside the U.S. for their instant cures. Medical tourism is growing. Currently over 100,000 Americans pack their bags every year and head overseas for their treatment, citing lower costs (15-85% lower according to Josef Woodson, author of *Patients Beyond Borders)* and claiming equal or superior treatment. But despite growing cynicism about U.S. health care, there is still no validation for this claim.

My patient Paul, an American literature professor now residing in Greece, does not agree that the treatment overseas is comparable. Scoffing at the medical tourists, he has always been sure to come to see me in New York every year for his check-ups. When he fell and smashed his wrist in 2002 and the blood supply to the joint was compromised, he was operated in New York by the same highly successful orthopaedist who had also fixed the ailing limbs of Patrick Ewing, Don Mattingly, and the Zaro the baker. Afterwards, Paul proudly flexed his wrist and proclaimed the "no frills" European health care system as his "health care of last resort."

In 2003, when Paul developed an elevated prostate test (PSA), I urged him to return to New York for a biopsy, to rule out Prostate Cancer. But Paul confessed that he was too low on funds to afford the trip or the procedure. At the time, he was living and teaching in Copenhagen, and the doctors there were more laissez-faire than I was, telling him they

thought the abnormal result was due to benign prostatic hypertrophy (BPH) rather than cancer. But in late 2005, as his PSA continued to rise, I was finally able to convince Paul's Danish urologist to perform the biopsy. The results were normal, though it was a "no-frills" biopsy with only 4 samples taken, half of the usual sampling technique utilized here.

Sure enough, Paul's PSA rose even higher, and as he began to have more trouble urinating, he finally had the biopsy repeated in Greece this summer. This time the biopsy was positive for cancer in both lobes of the gland, and his doctors in Greece recommended immediate radical prostatectomy to remove the prostate.

I contacted Dr. Herb Lepor, the chairman of urology at NYU who has done more than 3,000 of these procedures and is a pioneer of the nerve sparing technique which helps preserve sexual function. Dr. Lepor was eager to help Paul, and doubted he could find a surgeon with similar experience in Greece. Dr. Lepor indicated that choosing the best surgeon should be based on "experience, whether the outcomes are verifiable in peer reviewed literature, and there is a commitment to take care of the patient afterwards."

Paul was satisfied that Lepor represented the very best kind of surgeon available, not only based on statistics, but also intangibles. He called Lepor "an artist of the prostate." Unfortunately, Paul could no longer afford him, the way he had been able to afford the wrist artist years before. Instead, he had to settle for a local surgeon in Athens at the state hospital who came well recommended by other Greek doctors and patients.

The operation was a success, and now his wife nervously awaits the result of his bladder and sexual function. Paul's insurance covers everything, so his choice seems reasonable, unless the end result is less successful than what Lepor could accomplish on his worst day. Surgery is an art, and Lepor is a consummate American artist. It will be fortunate for us if we manage to overcome our erosive health care culture, and make sure that in the future we still have many here just like Lepor.

THE VIRTUAL HOUSE CALL

Medicine begins as a calling. In Medical School, we all hear about Hippocrates and Maimonides and Schweitzer, but how many physicians grow enough in their professional identities to be called modern-day healers?

The first time I considered this question was even before I became a medical student. I was surgeon Harry Soroff's young nutritional research associate at the Northport VA Hospital on Long Island, and I was assigned to his inpatient Al Gazzini. He loved to eat, but surgery to remove his esophageal cancer had left him so scarred that there was no easy way to reconnect what remained of his esophagus to the rest of his bowel. At first all Dr. Soroff could offer him was intravenous nutrition and the chance to chew and spit out his coveted pastrami sandwiches. On days when Gazzini's wife couldn't come to the Hospital, Soroff brought the sandwiches himself.

But Gazzini soon tired of this routine and urged his doctor to try to reattach his plumbing. Soroff finally agreed to a risky 10-hour operation, in a last effort to restore some quality of life for his patient.

At first, the operation appeared successful. and when I broke the news to Gazzini that he could finally eat a regular meal, he couldn't stop smiling. His first request: a juicy steak.

I ran home and grilled him a porterhouse that I wrapped in tin foil and brought it back to his room. He savored every morsel, nodding happily with each swallow.

Soon after, however, his wounds became infected, and Gazzini died. Soroff said he felt miserable about the outcome, but with an honesty that affected me deeply, he said that he never regretted performing the fateful operation.

I went on to Internal Medicine training and practice, where I have tried to apply the lessons I learned that day as I cooked Gazzini's last steak: Most patients will find a way to tell their doctor their major concern - if the doctor is listening. It was my first chance to see that inspired health care doesn't just happen. It wasn't my last.

Some doctors still buck the trend - the way Soroff did - and go to extraordinary lengths to give their patients personal care. Some let patients call them at home-day or night; some keep their offices open late for them; some find other ways to show a patient's outcome matters deeply to them. (At New York University's School of Medicine, professor of medicine Marcel Tuchman, 85, has even been known to call a cab for and accompany very sick patients to the hospital himself.

Patients who encounter this kind of care don't just find the difference striking; they credit it in many cases with health improvements they might not otherwise have realized.

Doctors have a choice; either we define ourselves based on our rate of reimbursement and view our patients as so many numbers, or, like teachers, we first define our professional

identities based on our training and engagement, and only seek reimbursement after we have set up our health care rituals. If this sounds too idealistic given today's enormous paperwork and cost-cutting insurance coverage, then consider the alternative, a doctor who retains his or her upper class status but not a heart or soul.

I have a litmus test to check on my humanity. I call it the "virtual house call." It isn't an actual house call but it relies on similar notions of inconvenience in order to help a patient. Rarely do we have time these days to travel to a patient's home. We must extend ourselves beyond our offices and our blackberries in caring for our patients in order to become truly empowered as physicians. This extension of self is the virtual house call.

Here is my litmus test: Every day I leave my office for a cup of coffee when I get restless. The coffee shop is one block south of where I practice. I ask myself what I would do if one of my patients, on his or her way to see me, suddenly collapsed right outside that same coffee shop I frequent and called my office from his cell phone while gasping for air.

Would I instruct my nurse to call 911, or would I run the same block I always walked?

Would I at least show as much commitment to my patient as I show to my caffeine habit?

I've never had to face this particular litmus test, but I certainly hope I would pass it. And each time I pick up the phone to check in on one of my patient, I'm conscious of a similar kind of litmus test. As I listen over the phone to the telling sounds of fast breathing or nervous coughing, I make determinations that my nurse or secretary could never make. I try to remain available, to not set strict limits. I'm convinced that continuity of care makes me a better doctor.

Even when I am off duty and being covered by another physician, I often try to remain reachable by cell phone or beeper. Extending myself to pre-emptively answer a quick question can help avert a larger problem later on. Of course sometimes I make a mistake when I respond too quickly to an unexpected call on a weekend – I have been too quick to resort to descriptive scare terms like "diabetes" or "pneumonia." Trigger words can quickly undo a doctor's benevolent intention and send him careening down a path of damage control and draining reassurances that wouldn't have been necessarily if he'd been a more careful communicator in the first place.

With the time pressures of today's medicine, every day is a challenge to my humanity as well as my effectiveness. I have to remind myself that the only satisfying way to practice medicine is as a healing art that knows no exact limits.

Of course my struggle to live in the world of the virtual house call occurs within the larger context of the controversy over the overall standards of U.S. medical care these days. A recent study by the Commonwealth Fund reported our health care to be the most expensive, but no longer the safest or the most co-ordinated in the world. According to

the Commonwealth Fund, we are last in terms of quality when compared to five other top industrialized nations.

COUNTRY	AUSTRALIA	CANADA	GERMANY	NEW ZEALAND	BRITAIN	UNITED STATES
Overall ranking (2007)	3.5	5	2	3.5	1	6
Quality of care	4	6	2.5	2.5	1	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy lives	1	3	2	4.5	4.5	6
Health expenditures per capita (2004)	$2,876*	$3,165	$3,005*	$2,083	$2,546	$6,102

*2003 data;
Source: The Commonwealth Fund

Of course quality of care is particularly difficult to assess, and there are many different criteria. The Commonwealth Fund study found that half of Americans didn't fill a prescription or skipped a medical test because of cost, compared with 13% in Britain; and 26% went to an emergency room for a condition that could have been treated by a regular doctor, compared with 6% in Germany. These statistics would seem to reflect a lack of caring and commitment on the part of America’s doctors, or at the very least a perception on the part of patients that their regular doctors aren’t ready to serve as illness guides.

According to a 2006 analysis by the Organization for Economic Cooperation and Development comparing health spending and health statistics in its 30 member nations, the U.S. spends an annual $6,102 per person — more than any other country and more than twice the average of $2,571. Yet Americans have the 22nd highest life expectancy among those nations at 77.2 years compared with the analysis' average of 77.8 years. People in Japan, the world leader in longevity, live an average of 81.8 years.

This report also found that Americans had fewer practicing physicians, or 2.4 per 1,000 people, than the average of 3 per 1,000 people.

At the same time, we continue to train top physicians at the top medical centers in the world, and quality medical care is still available everywhere in the U.S, even if it is no longer the rule.

Patients who encounter doctors practicing virtual house calls don't just find the difference striking; they often credit it with improving their health.

Internist Albert Herrera is one such doctor. The former chairman of internal medicine at Inova Mount Vernon Hospital, he practices in Alexandria, where my former patient Andrea, 38, sees him for regular checkups.

Recently, after starting a demanding new job as a public school registrar, Untrojb developed severe pain in her stomach. Herrera's diagnosis: a bacteria that thrives in stress-induced stomach acid and can cause ulcers. But he did more than treat her with antibiotics.

"Dr. Herrera talked to me for over an hour and asked about my job," Untrojb told me by e-mail. "He not only wanted to know about my physical pain, but wanted to find out what else could be causing my emotional distress. I told him that my job put such a strain on me that I was coming home crying every day, yelling at my kids and arguing constantly with my husband. Dr. Herrera reassured me that many suffered with this problem. He gave examples from his own life and told me what I could do to relieve the stress," including routines, meditation and exercise.

George Washington University medical school faculty member Jeffrey Sherman, 50, also tries to match his effort to the patient's need.

Sherman, a former National Institutes of Health immunologist who left research for clinical practice 12 years ago because he missed patient contact, gives out his cell phone and home phone numbers freely to patients and encourages them to call any time they have medical questions.

"This kind of thorough, thoughtful care is almost impossible to find," said Howard, a 36-year-old literary agent who saw Sherman recently after an outbreak of shingles. "He didn't seem rushed and sat with me to talk about my symptoms. He even took out a book and showed me which nerve endings in my head were affected by the shingles. He also talked me through the medication I was taking.

"When I mentioned to him that my wife and I might be planning our second child, he actually called me back into his office and looked up whether there were any risks associated with the drugs a future father was taking and the chance of birth defects. He found none.

"I think the worst part of being sick is fear of the unknown, which only gets exacerbated if your doctor is not communicating to you properly."

Over the next week and a half, Sherman called Howard three times to see how he was doing and to make sure the shingles rash and pain were abating.

Why don't more doctors practice this way?

It's not just a matter of the demands of managed care, though the system's rigid (some say stingy) reimbursement formulas and focus on the bottom line does make it more difficult to deliver devoted care. I still accept managed care insurance, as does Herrera. Cramming more patients into my crowded schedule would sure help me pay for my kids' private school tuition and for a badly needed renovation of my house. But I can't bring myself to do it.

I can limit idle conversation with my patients, but I'm concerned that too much attention to the clock will cut down on rapport and lead to missed diagnoses or poor treatments. Dropping managed care entirely would mean giving up patients I care about.

Sherman has opted out of all managed-care insurance plans and asks for payment upfront, though he makes allowances for patients who cannot pay the full rate. Because his patients have to cover the bill, he says, they "have more expectations," which he is determined to fulfill.

While doctors often blame their lapses in attention and rushed demeanor on time pressures exerted by managed care, others say they can only preserve their identity as healers by remaining engaged and caring, regardless of the reimbursement. Pauline Chen, transplant surgeon and author of "Final Exam: A Surgeon's Reflections on Mortality" (Knopf, 2007), writes: "That honor of worrying -- of caring, of easing suffering, of being present -- may be our most important task, not only as friends but as physicians, too."

It's too bad all doctors aren't as deeply invested. Part of the fault, Chen argues, may be in our training:

"Medical students must learn to endure and even embrace what might be considered by others to be difficult or even ghastly. . . . Ultimately they will settle at a comfortable equilibrium point, and this act of creating a new moral paradigm -- detached concern, secure uncertainty, and humanistic technology -- marks an important step in the transformation of the lay medical student into full-fledged professional physician."

Extraordinary caregivers also bend the rules to respond to a situation at hand.
When Candice, who'd just moved to Philadelphia after a 20-year career on Wall Street, developed a sore throat, fever, and an uncontrollable cough the Friday before Memorial Day weekend a few years ago, she called eight doctors, one after another, from a "10 Best" list in Philadelphia Magazine. No luck. In each case, she was told there was no room on the doctor's busy or curtailed, pre-holiday schedule. The ninth doctor, Jefferson Medical School internist Roger Daniels, was also booked, but he agreed to see Candice within the hour. He prescribed antibiotics for her bronchitis. Candice remembers his

nurse saying that he would never leave his office while patients were still sick and in need of his care.

A few months later, Candice arrived at Daniels's office for a scheduled visit with the beginning of a severe migraine. Instead of sending her home, Daniels let her rest in a darkened exam room for four hours, observed by his nurse, while the migraine slowly abated. Daniels has a busy practice but he never mentioned to Candice that she was keeping him from using the room for other patients. Later, he rode down in the elevator with her to the street, making sure she was well enough to get home on her own power. Then he returned to work.

"I didn't even know I had a bad doctor until I got a good one," said Candice. "With a good one, I trust his judgment, which is especially important when I have controversial health decisions to make."

Andrew Goldstein, 40, a gynecologist on the Johns Hopkins University faculty who practices in Washington, sees many cancer patients who develop vulval discomfort as a side effect of chemotherapy.

Like Sherman, he expects payment upfront: He charges over $500 for an initial visit -- lasting 1 1/2 hours, an almost unheard-of amount of time these days -- and $250 for follow-ups. The length of the initial visit, he says, is necessary to allow patients to "work through their anger over other physicians and come to real solutions."

Also like Sherman, he gives out his cell phone and home phone numbers. Patients, he says, are reassured by his availability and call only when absolutely necessary.

His patient Linda, a 59-year-old business consultant, notes that no nurse runs interference for Goldstein; he handles everything himself. "His empathy allows him to destigmatize a problem that is embarrassing to his patients. It's as if he's talking about your eardrum," she said.

As for the personal approach, Linda is sold. "If a physician is able to completely focus on you as a patient, the likelihood of an accurate diagnosis and appropriate treatment individualized to you is much greater. Not just an 'it seems like this, and therefore let's try that and see what happens -- come back next week.' "

It is clear from the daily practices of doctors like Herrera, Sherman, and Goldstein that health care is much more than just bald statistics about probability, necessity and risk. It is shaped by the quirks and characteristics of its practitioners.

When Dr. Jeffrey Siegel was killed by a hit-and-run motorist and taken this past summer at age 48 from his life as a prominent Long Island pulmonologist, the world lost a particular sort of physician. Our identities as doctors were molded in the Bellevue

Hospital melting pot of the 1980s when we were both learning to be caring physicians. He was the Siegel who cooperated; I was the Siegel (no relation) who fought.

Though he was my supervising chief resident for only a few rotations, I remember our clashes, as Jeff Siegel tried to teach me to be more politic and less confrontational. I was often arguing with nurses as well as patients, trying to get my points across, while Jeff was soft-spoken and known to be very persuasive.

Residency training was a cauldron, and as my medical personality was forged I began to learn from Jeff and others that I was often too forceful and that even when a patient's life is on the line it is still possible to negotiate. On the other hand, as I came into my own as a physician I also found that my outrage could help position me as a patient advocate.

Even with all the technology and the growing bottom-line thinking about cost-effective medical care, at the heart of the process are individual doctors who apply their personality traits to patient care. Jeff and I had very different styles, but we shared a tenacity that was essential at a busy city hospital like Bellevue. We were at our best as a team. Even as I was learning to be more politic, he was learning to be more gruff.

Once, a 55-year-old ironworker was admitted to the hospital with a severe heart attack and immediately demanded to leave the same day. As his resident, I was focused on keeping him alive medically.

I was so irritated at his self-destructive refusal of treatment that I began to argue with him relentlessly even as his stretcher was rolling him, still protesting, toward the operating room for cardiac bypass surgery. "You're giving me chest pains," he said, which brought me to my senses as I suddenly realized that I might be jeopardizing his heart further. It took Jeff, as my chief resident, to come by and calmly convince him to agree to the operation.

Afterward, Jeff quietly told me never to raise my voice with a patient, and he left it at that.

The surgery didn't go well, and in the recovery room, as the man's heart ballooned from damage and his lungs continued to fill with fluid, the staff was ready to give up. At which point I erupted in favor of toughing it out, this time directing my blunt insistence not at the patient but at the team working on him. Fortunately, we carried on, and the man's heart began to slowly recover.

I had learned from Jeff that there was little to be gained by yelling at a patient, but I learned for myself there was much to be gained from channeling my strong, stubborn emotions into not giving up. As he recovered, the patient began to see the benefits of my stubbornness on his behalf and grew to like me for it. Of course, he knew that he also owed his life to Jeff's very different intervention. He had strong relationships with both of us, which I am certain helped him get well faster.

Managed care medicine and health insurance policy arguments promote creation of the kind of physicians who are interchangeable, replaceable cogs in a complex machine that doesn't run as well as it used to. Yet I believe that the human element remains essential.

This was the lesson for me in Jeff Siegel's too-short life: Medicine is as much about the passionate personalities of those who administer treatment as it is about the technology that measures metabolism.

Of course, it is possible to take this lesson too far. Walter Chang is a 55 year old physical medicine (rehab) doctor who came to me for a sudden case of pneumonia which I treated with antibiotics and he quickly got better.

But in the course of examining him I discovered that he was at least fifty pounds overweight, his blood pressure was too high and he told me he could no longer sleep at night.

"What time do you get home?"

"Midnight. Then I can't fall asleep until one.

And I start again at six."

I told Dr. Chang that insomnia was associated with obesity, diabetes, high blood pressure, and difficulties concentrating, all things he was suffering from.

"A rehab doctor in the office so late? Why? You don't have any emergencies!"

"Dr. Siegel, you know how it is these days. Half my patients have no insurance or insurance that doesn't pay. Some are immigrants. But someone has to take care of them."

Walter Chang, caring physician, was jeopardizing his own health even as he performed his virtual house calls every day, well into the night. These house calls paradoxically took place in his own office, where he gave so much of his self that he was making himself sick in the process.

In the world of physician empowerment and self-actualization, Chang was taking his commitment a step too far.

THE ACTUAL HOUSE CALL

With the growing spottiness of American health care, it is not surprising that some of our best doctors have moved overseas for financial and logistical advantages. The numbers are far from sufficient to justify medical tourism, but this is still a disturbing trend.

We are number one in the world in diagnosing, treating and preventing important diseases such as diabetes and breast cancer, but as the Commonwealth Fund and the Organization for Economic Cooperation studies attempt to show, we may have fallen behind many other countries in terms of providing consistent quality of care.

One important measure of quality of care is the actual house call, which was rapidly becoming extinct in the U.S. by the 1960s. It has experienced a mild resurgence over the past decade as Medicare has improved its reimbursement for this humane endeavor.

When I think of house calls I think of my friend and mentor Dr. Ted Jones. Long before I ever met him he was a general surgeon in Rochester, New York, a pioneer in colon transplant, and the first to perform the patented metal mesh "Shulteis" technique of hernia repair in the U.S. in the 1970s. Jones may have been prescient about the decline in medical humanism, when, in the late 1970s, he left a thriving surgical practice to sail down the Erie Canal and across the Atlantic to Scotland. After a year establishing local credentials by running the trauma unit in Glasgow, he qualified for an island practice on the rural Isle of Mull off the northwest coast.

Jones never allowed standard practice limits to dictate how he practiced, which is one of the reasons he was more comfortable visiting the fishermen in their old stone huts on Mull than he ever was in the O.R.s of Western New York. I first met the well-worn doctor on Mull while I was a medical student on elective, and I spent several weeks accompanying him in his 1969 Morgan on his house visits, where I discovered that there were certain things about illness I could learn only by visiting the world it inhabits. Jones saw what his patients wore, what they ate, how they moved, and he was able to draw more accurate conclusions as a result. He was also able to visit patients who were too injured or infirm to make the trip across the island to his meager office.

Jones had trained at Bellevue Hospital in New York back in the 1960s, and had been drawn more to the dire straits of the patients he was treating there than the techniques he was using to treat them. As a result, he was happier on Mull than he had ever been as a surgeon. When he finally retired from practice a few years ago and moved to the Isle of Iona (Macbeth's island), off the backside of Mull, he spent the remainder of his days repairing the farm machinery of his former patients.

Long before Dr. Jones' reaction to a perceived change in the medical climate, pervasive changes in our society's regard for medicine had been a central cause for the deterioration in the physician-patient relationship. In the 18th century, when humanism as a movement was molding the zeitgeist, medicine was regarded as purely humanitarian.

But in the 19th century, when utilitarianism replaced humanism as a central societal philosophy, medicine began to be regarded purely as a utility. When individuals were sick, society was seen as not functioning at its best. The sick were unemployed and therefore burdensome, so medicine boosted the efficiency of 19th century society by maximizing the number of people who were fit to contribute.

At this point, medicine diverged from a private relationship between two individuals to a public relationship involving a social institution, or "one link in a great chain of social institutions." Medicine, previously considered a natural science, was now also a social science because its goal had become social. Health care1 was an important function in a state's administration, so the physician in a sense was similar to a civil servant.1

Unfortunately, when medicine became subverted by the social infrastructure of society, it became encumbered by bureaucracy, making it easier for medical care givers to lose sight of the altruism that was once supposed to be at the core of their work. The utilitarian approach, especially when coupled with bureaucratic confusion that distances the physician from the recipient of his or her care, inevitably submerges the intended humanitarianism of medicine.

As an instrument of society, a physician may approach his or her work in the methodical manner that typifies bureaucratic systems. The patient is seen through a series of impersonal filters, from insurance policies to malpractice caution to superimposed hospital or office health regulations. What was once a private relationship between two individuals has morphed into a social mandate, compounded by today's highly technical and specialized medicine.

House calls, which symbolize a willingness on the part of the physician to do the maximum in fulfilling his or her duties toward patients, require a deeper emotional connection between the physician and the patient. Many of today's physicians fall short of this connection, because, despite our scientific and medical acuity, we are empathetically less and less adept. And whereas the hospital and examination room are the physician's turf, a place for doctors to feel in control and empowered, the home is the patient's turf, and represents a challenge for any physician. House calls require advanced interpersonal skills as a visiting physician attempts to establish a relaxed and worthwhile connection with a homebound patient.

In Greco-Roman times, physicians were considered intellectuals straddling many different fields, such as astrology, diplomacy, theology, and even rhetoric. They were learned men, but not primarily in medicine.

Today's physician is too often focused only on medicine, making it harder to relate to patients in a more personal manner. Of course the house call has disappeared more because of impracticality than lack of caring. House calls are simply inefficient. They are poorly reimbursed for the amount of time spent, and if a physician were to visit homes regularly, he or she could not see as many patients.

House calls may also require special training, and medical schools and residency programs don't routinely expose trainees to house calls. (Although Mount Sinai Medical School has begun incorporating this training into their curriculum as part of a more humanistic curriculum).

The physician also lacks the personnel, equipment, records, and conveniences that we routinely rely on in our offices. Even minor procedures are more difficult, as few physicians travel with the necessary equipment. There are also more opportunities for lawsuits in an increasingly litigious society.

Despite the practical problems and the societal pressures to make the house call extinct, there are also many reasons to preserve it. First, house calls can restore essential humanism to medicine.

Second, the country's elderly population is growing. Two million people on the US are permanently housebound, so house calls are a great way to spare patients the discomfort, inconvenience, and expense of travel.

Third, controlled studies show that house calls can reduce the number of ER visits, the length of hospital stays, and the number of admissions into nursing homes.

Lastly, house calls are a source of reassurance for patients and their caregivers. For many patients with severe, chronic illness, their world is their home. A visit to a home can reduce feelings of isolation and loneliness for homebound patients. When a physician like Dr. Jones visits them there, they know they are being fully assessed and their caregivers prepared and informed.

A house call is an opportunity to assemble medical clues that can lead to more satisfying treatments – to assess a patient's function and safety by seeing which medications are actually being taken and how, leading to fewer errors and better patient understanding and compliance. The visiting physician can prevent falls by recognizing faulty banisters or hidden steps, delay admission to a nursing home, and check for abuse or mistreatment.

In recent years, there has been a small trend back in the direction of house calls because of boutique concierge medicine for the rich and Medicare reimbursements for the needy, even as a managed care society continues to promote the six minute office visit. Just as the virtual house call is a dramatic minority, so too the days of exchanging a home grown chicken for a doctor's visit are practically extinct.

STATS:

- In 1954, 10 out of every 100 patient-physician contacts in the US were in hospital clinics and emergency rooms; by 1970, this had risen to 20% (181 out of 860 million physician visits).[1]
- In 1964, family doctors were spending an average of 15.5 minutes in direct patient contact per office visit; this time had declines to 11 minutes by 1968. They worked faster as they grew busier and as they got to know their patients better. (Today's statistic is between 6 and 10 minutes)[1]
- In 1930, 40 percent of all doctor-patient visits were house calls. By 1980, this proportion had dropped to less than 1 percent.
- Physicians made about 727,000 house calls nationwide in 1993, compared to about 177 million office visits. The comparatively few patients who received house calls were of an average age of 82. Half of them were hospitalized the same year, and more than a quarter of them died. As expected, most of the physicians who made house calls were general practitioners, general internists, or family physicians, and many were in solo practice.
- About half of internists and family physicians still say they make at least one visit a year to a patient at home. However, Medicare records show that the total number of house calls is still low. According to a study in the *New England Journal of Medicine* in 1997 only 8.8 of every 1000 Americans 65 years of age or older received a house call.[1]
- In 1998, Medicare reimbursement for house calls was increased by almost 50 percent, (providers receive close to $100 for a typical house call today), and the number of house calls made by physicians in the U.S. increased by almost 15 percent from less than 1.5 million in 1999 to more than 1.7 million in 2002 [1]

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The Mission of CMPI is to discuss, debate and demonstrate how exponential and accelerating technological progress coupled with smart public policy will enhance and advance 21st Century health care by predicting, preventing, diagnosing, and treating diseases with greater speed, more precision and less cost. Peter Pitts, former Associate Commissioner of the United States Food and Drug Administration, and Dr. Robert Goldberg, a leading health care thought leader and former Senior Fellow at the Manhattan Institute, founded CMPI for Policy Research.

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