Who manages the managers?

The 1989 Harvey Cushing oration

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New medical knowledge is emerging at a tremendous rate. Diseases such as Alzheimer's disease, Parkinson's disease, cancer, and others (diseases once considered beyond the scope of medicine) are receiving a great deal of attention. Yet it is a paradox that, at a time when we are learning more about the biology of the human being, it is more difficult to creatively develop the new knowledge into diagnostic tests, surgical interventions, and preventive strategies.

The pace of biomedical innovation is being slowed by an increase in the intervention of nonmedical "managers of care." The driving force behind managed care is concern over cost. The managers of medical care have sought to control costs by controlling the doctor's decision making. This is the focus of managed care. The physicians of today, therefore, face a remarkable challenge. They must respond to the needs of patients while being held accountable to an increasing number of overseers in the public and private sectors. These managers of care justify their activities on the notion that the patient will be better off and the cost less if the doctor-patient encounter is regulated by protocols, statistical comparison, utilization review, and fee schedules.

While doctors' decisions are being managed by others, who is managing the managers? The answer should be the medical community, principally doctors. Unfortunately, the answer at the moment is the payors -- governmental reimbursement agencies, intermediaries, employers, hospitals, or new corporations designed to manage medical costs. The challenge to the physician is to retain the responsibility for those things for which he or she is held accountable. The challenge should not be ignored.

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YOU might not believe this, but when I was in high school, I competed in the Westinghouse Talent Search. I was asked what I wanted to be later in life. My answer was: a brain surgeon. I never made it quite that high up the anatomy. So you can imagine what a thrill it is for me to address the American Association of Neurological Surgeons. To be invited to give the Cushing Oration is a unique honor for me as well as a form of fantasy fulfillment. Were I able to talk with you about a spectacular new operation or neuroscientific breakthrough that I had developed, I would truly feel worthy of the orator's role. But I am not able to do that. I have been doing other things. I have been watching the health care system grow. The working of the health policy system in the United States is almost as mysterious to me as the working of the brain and nervous system. So, with the encouragement of your leader, I was asked to put forth my observations of what is referred to these days as "managed care." I will do that in a moment.

One of the things that helped me to understand what the association with Dr. Cushing meant was the film, "The 2000th verified brain tumor operation performed by Dr. Harvey Cushing, April 15, 1931." Dr. Richard Light, of Kalamazoo, gave that film to me and also shared with me some fascinating history regarding Dr. Cushing and your association. To Dick Light, my thanks. To all of you, thank you for the invitation, and, as Henry VIII said to Anne Boleyn, "I'll not keep you very long." . . . It may only seem that way.

Managed Care

It is a sign of the times that the phrase "managed care" appears in the news about the health care system with increasing frequency. Studies about the cost ef-
fectiveness of screening techniques, diagnostic methods, and treatments are now in vogue, even in the medical literature. Employment opportunities are expanding for managers of care. In fact, I have heard it said that new concepts of managed care appear to be the country's only hope of controlling our chaotic health care system. And one does not have to look too long for references to what is, in the minds of some people, the cause of the loss of control. As an aside, it is not unusual to hear that "doctors are out of control." It is not refreshing to read the Wall Street Journal's report on the application of positron emission tomography scanning.

Cost, of course, is the driving concern. Quality, even though it means different things to different people, is said to be eroding. Access to service is less readily available to more people. Discussions of why things are as they are rarely go beyond a few superficial facets of a large, complex set of social, legal, political, economic, technological, demographic, ethical, environmental, and public health issues. Paul Starr's book on the social transformation of medicine is worth studying. In another publication, Blendon recently asserted that only 10% of Americans see their health care system as working reasonably well. Furthermore, he stated that people in this country are substantially more dissatisfied with our health care system than are the Canadians or the British with theirs. He reported quite recently that there is an erosion of respect. We must be mindful lest we begin to complain like Rodney Dangerfield, that we don't get any respect.

Although the expectations of physicians remain high, admiration for the profession is declining. In report after report to the public, to the Congress, and to their employers, the new managers of care assert that physicians order too many tests, treat too many ailments with excessive therapy, and charge too much for their services. If doctors are not careful, they may be tossed into the same class as certain greedy executives of pharmaceutical businesses. The critics seem to have forgotten the maxim of James Madison, "Some degree of abuse is inseparable from the proper use of everything." I am certain Madison intended a general definition of abuse. While many reports make it clear that factors other than physician behavior contribute to increased health care expenditures, it is remarkable that virtually every analyst comes to the conclusion that altering physician behavior is the key to containing expenditures in all parts of the health care system. Their approach to modifying the behavior of the doctor is to control the doctor's decisions. This is what managed care is really all about.

Managed care is marketed by a variety of companies. Employers and third-party payors and hospitals buy the service. The sales pitch is that care management can: 1) reduce cost; 2) maintain or improve the quality of service; and 3) identify what you are paying for. The management team may include statisticians, accountants, health systems administrators, and a variety of health care professionals — including doctors. The appropriateness of clinical judgment is determined by comparison with statistical reports in the medical literature and institutional data bases, and by consultation. There is, as you know, wide variation on how such remote judgments about care are made. Therefore, the physicians of today face a rather remarkable challenge. It is not an overstatement to say that doctors find themselves in a quite difficult position: carrying out the mission for which they were trained — that is, responding to the needs of patients — while being accountable to an increasing number of agencies, companies, analysts, committees, overseers, government officials, lawyers, consumer groups, and the media.

Somewhere in the rationalization of these activities is said to be something that somehow devolves to the good of the individual patient. The groups are all, in fact, justifying their activities on the notion that the patient will be better off, the system will be better off, and the cost will be less if the key, the pivotal professional event — the doctor-patient encounter — were regulated by protocols, statistical comparison, utilization review, and (as recently recommended, again) fee schedules.

It is a paradox at a time when we are learning more about the biology of the human being, and doing so more rapidly than ever, that it is more difficult to creatively develop the new knowledge into diagnostic tests, surgical interventions, therapeutic agents, and preventive strategies. There is some encouragement to forge ahead, but much greater intimidation, if not out-and-out discouragement. "Slow down" is the message. As you well know, in the neurosciences new knowledge is coming forth at a great rate. New ideas to help individuals with conditions previously considered hopeless are emerging from all over. Brain injury, Alzheimer's disease, Parkinson's disease, cancer, schizophrenia, affective disorders, aging, and developmental disorders are getting a lot of attention. The prospects for success are good. But the managers are worried. Who is going to pay for all these things?

There are strident calls for information on practices to prevent disease. Nutritional, behavioral, and social advice are now commercialized. Yet the information that may provide the greatest ability to prevent disease is just now emerging, from genetics to molecular biology, immunology, enzymology, and protein chemistry. Just imagine what the opportunities for accurately predicting susceptibility to the great killer conditions could mean for the specificity of individual patient management. Think about being able to selectively enhance resistance to certain externally derived conditions, including infections. Think about the burgeoning use of certain growth factors in restoring the vigor of depressed bone marrow and other specialized cells and tissues. The prospects are outstanding, but how can we afford them? It is said that the pie cannot or will not get bigger (I am referring to the money pie, of course), so who
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will make room in the pie pan? Since doctors, it seems, cannot be trusted with resource allocation, the managers will decide.

As our standard of living increases, as our medical practices improve, as our preventive self-care improves, and as our fertility rates remain modest, we are becoming an older nation. As we have more people above the age of 50 years, our use of the health care system increases. And, as already indicated, we shall be able to do more for them. How will the managers pay for the increment of expenditure, based on economics and demographics?

The Health Care Alternatives

After enumeration of so many factors that make it absolutely clear that more resources will have to be spent, it is tempting to conclude that the health care system of the United States just cannot handle the situation. (I have not mentioned the urgent need to find the resources to provide decent care to the non-served and the underserved and the exploding cost of liability-related actions in the medical field, and the emergence of new disease challenges like AIDS (acquired immune deficiency syndrome) and sociomedical problems like drug abuse and alcoholism.) Such a scenario suggests to some analysts that we may need a nationalized system. In fact, some large employers are quietly musing about the timeliness of shifting the whole package of concerns to the federal government. It is not a particularly unwelcome prospect to some large companies as they begin to calculate the impact on their financial condition of actuarially determined future health care costs of employees and retirees.

Interestingly enough, it was labor-management negotiations in the early post-World War II years that resulted in a philosophy that raised the national priority of health care. Generations of Americans were encouraged to seek care early and often. More and better care was an unequivocal social good. A healthy worker with a healthy family was a good worker, a productive worker. That notion spilled over into other segments of society. Financial barriers to health services were lowered through Medicare and Medicaid, special programs for mothers and children, programs for the care of end-stage renal disease, and others. Biomedical research was encouraged and supported as a priority because it would improve the health of the people. I even recall symposia and Congressional hearings that tried to distinguish whether health or health care was a right.

Times have changed. I am not sure that people are less concerned about health. They are just more concerned about money. There is a hardening, perhaps even of the heart. It seems that society is now willing to accept that there is a percentage of the population without medical care or with substandard care, a sort of parallel to unemployment considerations. So now more is not better. In fact, there are many who seem to urge less care, less service, and say it probably results in better care (usually for the other guy), or at least better public health statistics. For my part, I follow the philosophy of Mae West on this issue. She said, “Too much of a good thing is wonderful.”

To the new managers of care, this issue presents a golden opportunity. For a fee, they will take your mind off the dilemmas of directing the choices, remote from the patient and driven by statistical profiles, ratios, and limits. We have an emerging form of nonlegislated regulation. Such a system has at least one redeeming feature: it makes jobs, the cost of which, incidentally, are usually included in health care cost computations.

Proposals for Health Care

It is not right for me to attack managed care as a solution to our problems unless I have at least a few ideas or proposals to deal with national needs. My observations and suggestions are as follows. First of all, I believe the pie will get larger, both in absolute and relative terms. That is, there will be more money spent and, as more money is spent in the health care system, those monies will constitute a larger percentage of our gross national product (GNP). There is nothing intrinsically wrong with this notion. It is a matter of priority. It is often argued that the United States spends too much of its GNP on health programs. A recent study authored by Bixby\(^1\) of the Social Security Administration puts these expenditures in a different light. A report from the Organisation for Economic Cooperation and Development\(^2\) reinforces the notion that we are not overdoing it — perhaps. These reports are commented on by Rich\(^3\) on the federal page of today's Washington Post.

These studies group health, education, and pension outlays of all kinds in the United States, both public and private. Our expenditures for all these categories, all of which impact on health studies, are approaching 30% of GNP.\(^4\) Expenditures in Sweden, West Germany, and France are higher (private contributions are not included in the European data). One could conclude that Canada and the United Kingdom spend about the same percentage of GNP as the United States on “social programs,” even though the outlays defined as “health only” are perhaps larger in our country. It is valuable to study what other countries spend. It is also valuable to analyze comparative public health statistics. However, it is simplistic to use other nations' expenditures as a target for policy purposes.

Second, I agree with Drs. Lois and Michael DeBakey, who have suggested that society must bring its expectations of health care into sync with the realities of modern-day medicine.\(^5\) To that must be added the notion that physicians must bring their practices into sync with the realities of our modern, socioeconomic system and our budget circumstances. Yet, in doing that, we as physicians must avoid being wholly incor-
porated into the business world's culture because: "Medicine is still first and foremost a moral activity; it has a noble tradition of compassion, altruism and public service." 5

Managed care is not built on that foundation. Managers of care have as their foundation the bottom line. Their principal objective is saving dollars, not saving lives. This is not to say, however, that they are insensitive to the human impact of their activities. I know that some actually believe they are improving the quality of services by acting like inspectors or foremen, as suggested by Donald Berwick of the Harvard Community Health Plan. 1 In fact, some of my best friends are now "managers of care."

To bring public expectations into line with the realities of today's capabilities requires a cultural modification or transformation. We tend to recoil from such a suggestion, yet just think of the mind-boggling changes in cultural norms that have occurred in the last 50 years. While we may not all agree on what is good and what is bad about the changes, none of us can deny that there have been changes. Much new knowledge and many new ideas have fueled the changes. Science and medicine, transportation, communication, economics, war, and many other things have played a role.

The underlying catalyst that accompanies an idea of change is communication capability — the force is knowledge and ideas. It is time for the profession of medicine to guide the American public to an understanding of the United States health care system so that the public can direct the government into policies that will realistically provide for continuity of progress, professional competence, universal access, quality services, and products at a reasonable cost. The profession needs to convince the American public again that their priorities are: first the patient, second the health of society, including all its segments, and, as a distant third, their own economic well-being.

My third suggestion is that we undertake soon an assessment of managed care. Clearly, the evaluation is not about how much money is saved, but about what impact this management is having on the patient and the doctor-patient relationship. The assessment must go beyond currently conceived outcome studies and must include patient satisfaction, community perception, and physician perception. As I indicated earlier, for all intents and purposes, managed care is a process for managing the doctor, not the patient. What is influenced most is the doctor's ability to make independent decisions. The managed-care concept also extends to team decision making. If remote or team decision making is an objective of managed care, then the medical schools had best look at how to incorporate the responsibility for the individual into this emerging system of diffused decision making.

Fourth, I think the medical profession should find out soon how the legal profession views modern managed care. As you are well aware, the impact of litigation continues to change the character of medical practice. Where does the manager of care fit into the mosaic of responsibility?

Fifth, state health professional licensing authorities need to look again at what the license they grant means. It seems to me that, with so many people now participating (at least indirectly) in the decision-making process relating to the care of the individual, there must be a reaffirmation of at least the principal responsibility for medical care. Many questions should be asked, like: what quality control does the state insurance commission exercise over those individuals or groups who manage care? Should not someone look at this?

Finally, doctors need to seize the initiative in helping to solve problems at the local level as well as at the national level. We should expand and upgrade our voluntary work to provide care to the homeless, and to the other disenfranchised and abandoned. We should do this with minimal expectation of assistance from any governmental agency.

We must retake the high ground in national policy debates. If there needs to be additional multisource financing, or means testing, or the federalization of Medicaid, or even (perish the thought) further regulation of provider payments, let us approach the debate with some sense of what is most important, and of who is responsible for what. If we do not come forth with ideas, policy will be made anyway. Even if we avoid new health insurance legislation, we shall back into policy fashioned by the managers. It will still be the doctors (not the managers) who will be accountable, at fault for all the failings and deficiencies of what still is the greatest combine of health care potential in the world.

I believe the answer to the question of who manages the managers should be the medical community — principally doctors. Unfortunately, the answer at the moment is the payors, be they governmental reimbursement agencies, intermediaries, employers, hospitals, or new corporations designed to manage medical costs. Even in most so-called "socialized" systems, where financial limitations sometimes exclude or limit certain procedures and ration certain services, the management of the patient is left to the doctor. The challenge to the physician is to retain the responsibility for those things for which he or she is held accountable. The challenge should not be ignored. Remember the observation of Erich Fromm: "The history of civilization is a graveyard of great cultures that came to catastrophic ends because of their incapacity for planned, rational and voluntary reaction to challenge."

I doubt very seriously that Dr. Cushing would have even grudgingly accepted instructions over the telephone from a management person that a patient be discharged from the hospital just because the statistics said so.

References
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