Special Article – From the ‘learned leech’

Medical police in the twenty-first century

George A. Silver

Emeritus Professor of Public Health, Yale University School of Medicine, 590 Ellsworth Avenue, New Haven, CT 06511, USA

American physicians may be envied for the size of their financial reward, but not for the burdensome conditions of American medical practice. The physician in the USA is under more severely restrictive regulation than colleagues in most other countries. This is paradoxically the result of the strenuous efforts of the organized medical profession to resist control by a governmental bureaucracy. Costs have multiplied, apparently uncontrollably. The multiplication of individual insurance plans, parallel governmental insurance plans, employer participation plans and the associated institutional efforts at cost control gave rise to a blizzard of paperwork. It also gave rise to a bureaucracy in both the private and public sectors and the public and private insurance regulations that were required to manage the paper flow and financial transactions.

Doctors and hospitals have been called to account as inflation of costs, obstacles to access and receipt of care has aroused anger and fear. For their sins, it seems that the medical police are about to be called in.

Actually, the need for the development of stringent control measures is only about 25 years old. Government-sponsored and -supported insurance for the elderly (Medicare) and government-provided medical insurance for the eligible poor (Medicaid) became law in 1965. Before that, the physician was in fairly complete command of medical decision-making. Charges were set by the doctor, with some deference to the patient’s financial situation, of course, but with little regard for the private insurance fee schedule. Laboratory studies, X-rays or specialty consultations were ordered as the doctor saw fit. Hospitalization was the doctor’s prerogative.

Since then, as the cost of the two programmes has ballooned, from an estimated few hundred million dollars in 1966 (never held down to that!) to the present nearly $150 billion, together with the parallel cost increases for the rest of the population, strenuous efforts at cost control have been undertaken. There were measures aimed at limitation of capital expenditures, reductions of length of stay in hospital, planning principles to reduce overall expenditures, and specific reductions in reimbursements, whether diagnosis related groups (DRGs) or fee schedule cutbacks. Nevertheless, whatever the approach over the years, the inflation of costs, well above the general index of inflation, continued inexorably.

Other measures having failed, sterner steps were taken to limit the doctor’s freedom to prescribe—not only medications, but diagnostic and therapeutic measures of all kinds. Government, along with employers and the private insurance industry have set their sights on severe limitations of use by patients, reduced payments to doctors and hospitals, and restriction of use of expensive technological machines. Within the past few years, a number of devices have been employed to accomplish these ends. ‘Managed care’, for example, allows the patient access to a service other than in the doctor’s office only by that office doctor’s permission. For elective procedures, the doctor must receive prior approval by telephone from the insurance company. ‘Preferred providers’ have agreed to a prearranged reimbursement with the insurance company. A patient who elects to use someone other than the preferred provider will not receive the full benefit of the insurance—or perhaps none at all.

To enforce the regulations, further steps were necessary. Collection of data had to be improved, in order to clarify charges and payments. Computerized systems had to be put in place. The Office of the Secretary of Health and Human Services has an Inspector-General with a staff designed for investigation and enforcement.

The activities of every practising physician are now coded for reporting purposes, to measure conformity and for comparison. CPT (current procedural terminology), for example, was introduced to permit comparisons when the physician reported reimbursable procedures; and the ICD-9 (International Classification of Diseases, ninth
became the associated bible for comparing physician diagnosis with the procedure. Computer efficiency requires the UPIN (unique physician identification number).

The only step lacking to assume absolute control of physician behaviour is a standardized description of diagnosis and treatment. There are now underway studies on medical services outcome, statistical studies of the effectiveness of certain procedures and under what conditions these procedures can be applied. When these ‘outcome measures’ resulting from the studies have been completed, a manual can be prepared in which the proper diagnostic measures and suitable therapeutic measures for specific diagnoses will be coded. The resulting ‘clinical guidelines’ will then be published.

In the computerized future, with a numerical formula representing the selected clinical guideline for the diagnosis (ICD-9), a judgment can be made of the appropriateness of the procedure (CPT), prescribed by the physician (UPIN). The coded factors will complete the circle in evaluating physician behaviour, and the computer will spew out whether it was (a) correct behaviour and (b) if so, his reimbursement. This will be forwarded, on line of course, to the Inspector General’s Office, where the information will be filed under the UPIN. From this file, his and her ‘profile’ of behaviour will be analysed and if his or her behaviour is too frequently (more than 2 sigma) incorrect, some disciplinary action will be taken: a monetary fine; perhaps return to hospital training; or loss of licensure. Malpractice suits will be a thing of the past. Either the doctor or the patient will receive benefit from the computer’s judgment.

European physicians may be watching the unfolding of this process with a mixture of horror and satisfaction, the comeuppance of their wealthy American colleagues. The schadenfreude may be quickly dissipated as the politicians and administrators in their own countries undertake similar control measures. European physicians should keep in mind that it was American physicians themselves who brought this loss of independence on themselves by stubborn opposition to taking leadership in reform measures that might have led to a more cooperative alliance with government.
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doi: 10.1136/pgmj.69.810.306

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