Almost 5 years ago I assumed an administrative position at Long Beach Memorial Medical Center, which is a 741-bed tertiary teaching hospital in Southern California. My title is Medical Director, but in other hospitals I might be known as Chief Medical Officer, or even VPMA because these terms have overlapping definitions. At any rate, I assist the elected medical staff leaders with their duties and participate in senior hospital management decision-making and operational functions. I still have a small gynecology practice, but the vast majority of my time is spent in the hospital. Most of the meetings I attend these days are directed to physician leaders such as myself, and I have gained a perspective of medical care that I want to share with you.

The health care system in our country is in crisis. Indeed, if there is any system at all, it must have been designed by the devil as suggested in an allegory related by the Princeton economist and frequent commentator on health care, Uwe Reinhardt, in which he recounts how Satan made a bet with God in the early 1940s that he could get more doctors into Hell if he were allowed to design the health care system in the United States. God didn’t think he could do it, so he agreed.

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Without going into the evolution of our dysfunctional system, which some say could only have been designed by the devil, we find ourselves today with an excess of doctors and hospitals in some areas of the country, leading to fierce competition and a loss of congeniality even among former colleagues. There has been a decline in compensation for many physicians, causing them to leave practice, move to new locations, or become resigned to a joyless existence. Many hospitals are awash in red ink, and some are closing. For hospitals and doctors alike, there are mountains of regulatory requirements and unfunded mandates.

We have seen the intrusion and then the collapse of Wall Street opportunists who attempted to profit by acquiring hospitals and physician practices. Despite spending 14% of the gross national product on health care, there are still 42 million Americans without health insurance. There are 7.2 million of them in California alone, and the number is growing by 30,000 per month. This has led to massive overcrowding of hospital emergency departments, which are being used by more and more of the public as their primary source for medical care, and then only when they get sick.

Even though many Americans have access to the finest medical care in the world, far too many people are underserved, including children. Although most Americans like their own doctor, there is generally diminished respect and confidence by the public in the medical profession and an almost overwhelming belief that medical care is being compromised in the interest of profit.

I think all of us wish things could be better, but change is difficult and often does not occur until the pain of the current circumstances exceeds the fear of altering the status quo. Perhaps we are almost there. The challenges of change have been described in a recent popular book, Who Moved My Cheese?, written by a physician, Spencer Johnson, and I recommend it to you.

One of the barriers to changing the health care system has been the fact that many of us personally benefited from the old way, and did not recognize the forces that
would lead to the present circumstances. Some of us even wish things could be the way they used to be.

But there is no turning back the clock. Whether we like it or not, change is inevitable—but progress is not. I believe things could actually get worse. The possibilities resulting from the human genome project and the rapid pace of technologic advances present enormous opportunities for the future. They also carry significant risks of commercialism and inappropriate utilization, which would result in more regulation and conflict over control.

What is really in question, then, is not whether things will be different in the future, but whether changes will be directed by insurance companies, the government, or Wall Street opportunists, or can physicians lead the way? If we do not exert our influence and provide strong guidance, I believe our very status as a profession is at risk. I believe doctors may have only a short time left to provide leadership before we become a completely regulated industry. There are those who believe we are well on our way to that fate already.

If physicians are going to be effective as leaders of change, I believe there are three major issues that need to be addressed. They have to do with modifying physician’s attitudes, restoring the public confidence, and developing strategic alliances.

First of all, can doctors actually act as change agents? The path to becoming a physician requires certain personality characteristics that are further honed during professional education and expressed during careers. Doctors are competitive and they prize autonomy. They tend not to trust others and to personalize issues, making it hard for many of them to be team players. They often view things from a win-lose perspective rather than search for a win-win solution, and this attitude often makes it difficult to negotiate successfully.

Although these characteristics are useful in the operating room, they may present barriers in the Board Room and make it difficult for us to be leaders of change. Many doctors become discouraged at their lack of effectiveness on hospital or other committees. It has been my observation that it is often because they are woefully unprepared for the job. There is a steep learning curve, and then their term of office is over, and a new, equally unprepared physician takes over.

I believe we should reassess how medical staff leaders are chosen and whether the traditional rotational process, with short terms of office, is the best way to ensure effective physician input. I also believe that physicians should be encouraged to participate in leadership training programs prior to assuming medical staff or medical group positions. Just as doctors must learn how to do surgery before they are allowed in the operating room, I believe they need to learn business, team building, and negotiating skills before assuming leadership responsibilities.

There are training courses now available through the ACPE or VHA, and several universities have courses on medical management available to practicing physicians. All hospitals and medical groups should invest in this sort of preparation for their medical leaders.

The second challenge is to regain the support of the public. The following is a quote from a talk given by Regina Herzlinger, who is a professor at the Harvard School of Business and the author of a recent book about winners and losers in our market-driven economy.

The future of the health care delivery system in the country is in the hands of the “new consumer.” Don’t misunderstand me—we have not transferred control, rather, they have seized it from us. For those who understand and accept that fact, the future is unlimited. Those who resist and fail to accept this reality will perish, and remain only as a memory of the way health care used to be.

The “new consumers” she is referring to are primarily that group also known as “baby boomers.” These folks have been one of the most manipulative and influential forces ever seen in our society. They want things done their way, at their convenience, and they will reward those who assist them and bury those who stand in their way. Nine thousand people turn 50 every day and enter an age when medical care becomes more significant for many of them. If you examine demographic trends, this can be portrayed as a wall or tidal wave of people who will continue to demand and consume more and more health care resources as they get older and as longevity is increased.

In order for us to utilize the power of this force, we must regain the confidence and support of the public. To do so, we must be able to critically look at ourselves and our practices to see what we can do to improve our image.

We tolerate far too much variability in the approach to many frequently encountered medical illnesses. Several common conditions were presented to a group of 135 family practice physicians to determine how they would manage the problems. In one example of a healthy young woman phoning in with classic symptoms of an uncomplicated urinary tract infection, there were 82 different management strategies with a range in cost from $10 to $250. This study is a little old, and I wish I could say outdated, but there is still unnecessary variability in the treatment of many conditions. In fact, the spread in costs today might be even greater because some doctors would undoubtedly prefer to prescribe one of the newer and more expensive antibiotic regimens as first-line treatment.

Two or three of us in this room could get together and design a clinical action plan to deal with this problem quite satisfactorily in a couple of ways that would yield good clinical outcomes and be cost-effective. But can you
imagine what would happen if you went home and told everyone else they had to use this protocol developed at our meeting? Howls of protest! “That’s cookbook medicine!” “You might miss something!” “My patients are different!” “Medicine is an art!” “Just send me more money so I can continue to do what I want to!”

There is also tremendous variation in the provision of medical care throughout the country based on geographic distribution. This information was compiled by John Wennberg, MD, at Dartmouth and illustrated in The Dartmouth Atlas. According to data derived from analyzing Medicare billing data from 306 hospital regions throughout the country, there appears to be a tremendous geographic disparity in the delivery of health care services such as surgical procedures, hospital admissions, and the performance of preventive health measures. This difference cannot be explained on the basis of the incidence of disease or by demonstrated improved outcomes for one approach or another but seems to reflect practice style, availability of resources, and the aggressive use of screening modalities.

The rates of surgery for back pain and prostatectomy are extreme examples, showing an 8-fold difference from one hospital region compared with another. Does this mean that too much surgery is being done in some parts of the country, or not enough in others? There are insufficient data to draw conclusions at this time, although there is no proof that clinical outcomes are better in one area compared with another. This is to say nothing of the fact that many of the procedures have very serious side effects, which occur in a significant number of patients.

When adequate clinical trials and cohort studies are lacking or poorly designed, best practice is impossible to determine, and treatment decisions are largely left up to the discretion of the surgeon. Unfortunately, the patient has frequently not been able to participate sufficiently in the decision-making process. Particularly in the case of discretionary surgery, individual patients differ substantially in how they assess their own circumstances and what they are willing to risk to gain potential benefits. A study was done by a health maintenance organization comparing the incidence of transurethral resections of the prostate for benign prostatic hyperplasia (BPH) before and after a shared decision-making plan was undertaken. When patients were thoroughly informed and educated about the risks and benefits of the proposed procedure, the rate of surgery dropped more than 40% below the group’s baseline.

Medicare reimbursement for hospital care alone for BPH exceeds $1 billion dollars per year. If the benchmark established by the shared decision-making process for surgery actually represents the preferences of patients, reducing the rate of surgery by 40% across the country would save more than $400 million per year for this one procedure alone.

Waste and overutilization are imbedded throughout our health care system. It has been estimated that for as many as 50% of the procedures performed in the United States, there are no valid data demonstrating the superiority of that procedure over more conservative measures. Randomized prospective studies are badly needed to evaluate not only new procedures, but many of those now commonly performed for which no conclusive evidence exists that the outcomes are better than with more conservative measures. Patterns of treatment are so ingrained, however, that specialty groups seem unwilling to participate in clinical trials. A recent study in the Journal of the American Medical Association reported that 93% of urologists recommend surgery for prostate cancer in young men, whereas 73% of radiation oncologists recommend radiation for the same condition.

One of the core concepts proposed last year at our annual meeting was to promote evidence-based medicine. Although we may have inserted the term in our lexicon, we have not imbedded it in our culture. Quality in health care should mean doing the right thing in the right way. Most studies of quality and outcomes, however, consist of determining whether what was done was performed correctly and not whether it should have been done in the first place.

It is equally disturbing that many treatments and preventive services that have good evidence of effectiveness are not being utilized in many areas. Another recent article in the Journal of the American Medical Association reports on the “Quality of Medical Care Delivered to Medicare Beneficiaries,” and I am embarrassed that my state of California ranks forty-first in the performance of these services. Does this represent a knowledge gap, or are there economic reasons why these services are not being done?

If we physicians fail to define best practice and what constitutes medically necessary treatment, that decision will be mandated by the government or by insurance companies. The Dartmouth Atlas is already being promoted to the purchasers of healthcare such as the Pacific Business Group on Health. These groups, and even the public, question why reimbursement should be provided for procedures and treatments that have no demonstrated superiority over more conservative and less costly ones. We as a nation spend more money on health care than any other country in the world. If we could eliminate the waste and overutilization in the system, there would be money available to more adequately reimburse physicians and hospitals for truly needed care. We might even find a way to provide health insurance to the 42 million Americans without it.

In addition to improving our credibility with the public, we need to improve the way we communicate with our patients. In many cases, the sacred trust that should be developed between doctor and patient has been replaced
by a set of rushed interactions. The result has been a re-
duction in satisfaction for patients and doctors alike. In
fact, I believe this diminished relationship is one of the
primary reasons why so many doctors feel unfulfilled in
their chosen profession.

If we are to improve that interaction, we need to con-
sider the fact that the “new consumer” is better educated,
is better off financially, and has access to more informa-
tion about health care than ever before possible. These
individuals want guidance from their physicians, but will
not tolerate a paternalistic approach. “Trust me, I’m your
doctor” doesn’t work anymore.

Because it is unlikely there will be more time to spend
with patients in the future, successful physicians will use
technology to extend and enhance their influence. There
is an explosion of Internet resources available, and
it is estimated that more than 50% of the public has ac-
cess to it. Although 70% of patients would like to receive
information from their doctor, fewer than 10% of physi-
cians use the Internet for patient contact, and many of
those only in a rudimentary way, such as linking to sites
for medical information.

It is likely in the near future that patients may select
t heir doctors directly by using the Internet, just like some
of you may have purchased your airline tickets to this
meeting on-line. It is likely that patients will be able to
make appointments, get drug refills, and ask questions
utilizing web-enabled technology. Physicians will be able
to provide preoperative and postoperative instructions,
monitor disease management protocols, and provide pa-

tient-specific information to improve compliance with
treatment recommendations and preventive health mea-
sures.

Believe me, all of this is coming, and although there is
a huge potential for benefit, there is also the risk of mis-
use. C. Everett Koop, MD, has commented that “incorrect
or misleading information glows with the same degree of
electronic intensity as does ethical communication,”
which is why it is so vital for doctors to be in the forefront
and participate in developing this technology. Otherwise
we may find ourselves in the position some of us did when
capitated managed care became so pervasive, and asked
after the fact, “How could this have happened?”

Many patients are interested in, and I believe we
should appreciate the importance of, the mind/body con-
nection. Americans spent more cash out of pocket
last year for alternative treatments than they did for tra-
ditional medical care. Some of us have heard presenta-
tions this week on complementary/integrative medicine
and visited the North Hawaii Community Hospital where
modern medical care is integrated with nontraditional
healing modalities.

I believe the popularity of so-called “alternative medi-
cine” is not based solely on the fact that some of these
treatments may have benefit. I think an increasing num-
ber of people feel that something is missing from the tra-
ditional physician’s armamentarium, stressing drugs and
surgery, but not spending much time explaining other
options. Armed with the information they have gained
from the Internet and other sources, even though some
of it is unreliable, the “new consumer” is looking else-
where for reassurance and relief, particularly from the
disabilities of chronic disease.

Physicians first and foremost should be healers, and
I believe we should be aware of complementary/alterna-
tive methods including the use of herbal preparations so
we can assess their impact and be able to discuss with pa-

tients their real risks and benefits.

We should also recognize the enormous power the
human body has to heal itself, and how important stress
and lifestyles are in promoting or blunting that capability.
We should look at medicine and healing in its totality. We
should not close our minds to innovation and unconven-
tional methods, but evaluate effectiveness with the same
yardstick whether it is from the traditional scientific
model or based only on empiric data.

Is the treatment safe? Is there valid evidence for its effi-
cacy, and is the well being of the patient the primary em-
phasis?

If we judge all therapies in this way and use our im-
proved credibility and the powerful technology we have
available, we will be better able to fulfill our obligations as
physicians to our patients and advisors to our communi-

ties.

In addition to gaining the support of the public, I be-

lieve physicians should align with hospitals to achieve
maximum influence on the health care system. Hospitals
exist only to provide facilities and services necessary to
help physicians deliver medical care to the community.
We do it together.

Traditionally, there has often been tension if not an
outright adversarial relationship between the medical
center and the medical staff. To be successful today in this
market-driven economy, we must work together. In addi-
tion to utilizing hospital facilities for the care of patients,
physicians can benefit from the hospital’s ability to ac-
quire capital in order to develop programs and obtain
the complex and expensive technology required to de-
velop the outcome studies and other data we have been
talking about.

Together, medical staffs and hospitals can gain market
share and successfully negotiate with insurance compa-
nies who would prefer to divide and conquer so they can
set policies and determine reimbursement rates based
only on how to maximize their investors’ profits.

Hospitals and doctors can also work effectively to influ-
ence legislation. The government is a huge player in the
health care industry. Medicare accounts for more than
40% of the revenues at our hospital, and the state Medi-

caid program for another 15%. Nothing throws more fear
into the hearts of hospital administrators than the threat of being excluded from these programs.

Medicare believes in the Golden Rule, meaning that “he who has the gold makes the rules.” The innocent-sounding “conditions of participation” means that if you want to receive reimbursement for federally funded programs, you will follow the regulations or be dropped. Many of these rules greatly complicate hospital/physician relations and contain unfunded mandates that are hard to comply with. Bureaucrats enforce the regulations and are often rigid and inflexible in their interpretations of the rules. The only way to correct some of these poorly conceived ideas is through the legislative process.

The baby boomers also look to politicians to create change if they cannot have what they want, and more than 100 bills are introduced in the California legislature yearly dealing with health care. When hospitals and physicians remain unaware of these issues or seek to settle their own differences by creating new laws, not only are the results unpredictable, but there may be long-lasting unintended outcomes that may be hard to reverse. Working together, however, hospitals and physicians can create a powerful and effective influence so that with the support of the public, legislation can be crafted in a more rational way, and in some instances, ineffective laws and regulations can be amended.

Working together does not mean that doctors should sell out to hospitals or be controlled by them. That has been tried, and it has not turned out very well. Physicians and hospitals can develop other sorts of partnerships, however, and work together to achieve shared goals and meet community responsibilities.

Well, there you have it. I have outlined areas that I feel need to be addressed if physicians are to lead medicine into the 21st century and help reverse a dysfunctional system. We need to identify and support physician leaders, improve our credibility to harness the power of a disenfranchised public, and form alliances with hospitals.

This is not really new information, but I believe it needs to be reemphasized because I don’t see that improvement is occurring very rapidly. From my vantage point, I hear a lot of complaining from doctors. I see a lot of hand wringing, finger pointing, blaming, and gnashing of teeth. What I do not see are very many physicians who are willing to step up to the plate to help create a better future. It is difficult to get physicians to assume positions of medical staff leadership. Our medical societies seem to expend most of their energies in reacting to circumstances rather than initiating programs that could improve the delivery of health care such as studying ways to reduce the geographic variability in medical treatment. They suffer from lack of membership and resources, and all physicians should join these organizations to improve their representation and their effectiveness. Many hospitals are not aggressively implementing the quality measures that are missing, and although the public and the government are expecting us to do whatever is needed to ensure patient safety within our hospitals, many medical staffs are slow to implement process improvement.

I believe there is a very real urgency for physicians to assume leadership while there is still time. Changes will occur with or without our input. The reason I chose this subject for my presidential address is because the people in this room can make a difference. Despite the fact that some doctors are reluctant to change and others do not think anything can be done, I remain optimistic. Studies have shown that it is not necessary to convince everyone in order to create change. If the opinion leaders in a group embrace a policy, the rest will follow. The fellows in our society, the physicians, and their spouses and friends are among the most respected individuals in your communities. You are the opinion leaders, and if you believe physicians can help create a better future, we’ve got a chance.

The road will not be easy. Success will require commitment and hard work. But philosophic discussions and good intentions are not enough. Action is what our patients expect, our communities demand, and our futures depend on.

REFERENCES