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Health Reform and the Practicing Physician

Resources

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FROM THE EDITORS
Leading through Change

Can I get a grande latte, double shot of espresso with skim milk and Splenda? Every day, millions of beverage orders are taken and successfully delivered at thousands of franchise coffeehouses around the world. Being able to get a good cup of joe (at five dollars a pop) no matter the time of day or the specific store location is a convenience that we have come to expect and probably take for granted.

While few of us, if anyone, would compare the selling of coffee to the delivery of medical care, there are many who argue that the health care system is not delivering quality service in the consistent manner, independent of geography or time, that all patients expect and deserve. Calls for the health care sector to adopt and learn from other industries abound, from information technology, as with the financial services sector, to the safety protocols and culture institutionalized by the airline industry. Whether or not other industries provide meaningful examples of how the health care system can be improved is open for debate, but regardless, change is coming. In this issue of *Virtual Mentor*, we explore the opportunities and uncertainties that health care reform will bring to physicians and the medical profession.

Accelerated by the passage of the Affordable Care Act of 2010, health care is in the midst of a seismic transition from a cottage industry made up of thousands of small businesses to one that is increasingly consolidated around integrated systems of care. As author and teacher Robert Martensen, MD, PhD, writes in the history of medicine section, the explosion in high-tech treatments and Medicare's outsized influence on medical priorities, coupled with what he calls its "laissez-faire" approach to reimbursement, combined to put acute care at the center of the medical solar system. This has not been good for primary care and the chronic illnesses that require continuity of management—not to mention the financial sustainability of the health care system.

New paradigms are being sought to ameliorate these problems in concert, improving outcomes while reducing unnecessary costs. The vice president of the American Medical Association's ethics group, Audiey Kao, MD, PhD, suggests in his policy forum piece that professionwide agreement about the meaning and appropriateness of stewardship in medicine could lead to a more sustainable health care system. In her case commentary, Lisa M. Gangarosa, MD, professor and division chief at UNC School of Medicine, considers how doctors should respond to patient requests for nonindicated screenings. Gordon H. Smith, JD, the executive vice president of the Maine Medical Association, describes Maine's pilot program to reduce the practice of defensive medicine in certain specialties by assuring legal protection for doctors

who follow particular guidelines. Another proposed way of reducing overutilization of resources, improving outcomes, and lowering costs is the institution of pay-for-performance programs, in which compensation is received based on outcomes, rather than on treatments performed. This month's excerpt from the AMA *Code of Medical Ethics* concerns how to design such programs around the best interests of the patient.

One practice model incorporating pay-for-performance is the accountable care organization (ACO), in which all departments and practices that participate in an episode of care share payment—and incentives earned by savings. The ACO model was tested in the Centers for Medicare and Medicaid Services' Physician Group Practice demonstration. Todd Ferguson, PhD, research associate for the AMA's Ethics Resource Center**,** reviews assessments of the project in the journal discussion section.

How will all this change medical practice? Thomas J. Nasca, MD, the CEO of the Accreditation Council for Graduate Medical Education, points out that if Medicare funding for graduate medical education is cut, responsibility for educating the next generation of doctors will fall to the profession. In the medicine and society section, Randy Wexler, MD, MPH, professor of family medicine at The Ohio State University, predicts that coordination of care will greatly improve, doctors will end up taking a much more active role in preventive care, and patient access to care will have to increase dramatically, perhaps with office-hour changes to accommodate patients' schedules.

In the short term, these changes may influence doctors' interactions with patients in a different way. Jack P. Freer, MD, professor and division chief at the University at Buffalo, takes political questions in the exam room as a jumping-off point for patient education in his clinical commentary.

What changes do new doctors and doctors-to-be anticipate as a result of health reform legislation? In one of November's two podcasts, *Virtual Mentor* asked Alexander Ding, MD, a resident physician at Massachusetts General Hospital, and Jordan VanLare, fourth-year student at Columbia College of Physicians and Surgeons, how they envisioned the medical practice environment they were soon to enter.

In the second November podcast, AMA President Peter W. Carmel, MD, answered *VM*'s questions about the sustainable growth rate (SGR), the formula by which Medicare calculates payments to physicians, and how the Affordable Care Act may affect the future of those payments.

The close connection between legislation and the everyday practice of medicine has led some physicians to become more actively involved in the political process. In the medical narrative section, child psychiatrist Scott M. Palyo, MD, recounts his experiences as a congressional fellow during the period health reform was taking shape. He found that physicians' contributions to the legislative process can be

crucial. Rice University health economist Vivian Ho, PhD, echoes this conclusion in her op-ed. But do physicians have an *obligation* to participate in politics? The case commentators of the first clinical case, University of Alabama at Birmingham professor Thomas S. Huddle, MD, PhD, and oncology resident Kristina L. Maletz, MD**,** take up this question.

The reforms, enacted and yet to be, haven't been popular with everybody. The ACA's mandate that individuals purchase health insurance, for example, has been a matter of strong controversy. In a policy forum piece, AMA senior research associate Valarie Blake, JD, MA, gives some background on the American Medical Association's view of the individual mandate, and medical student Eugene B. Cone gives us an "inside the beltway" look at the history and original intent of the congressional budget reconciliation process that was ultimately used to pass the ACA. In the health law section, law students Lizz Essfeld and Allan Loup review the legal challenges to the ACA's individual mandate to purchase health insurance. Michael F. Cannon, MA, JM, director of health policy studies at the Cato Institute, takes a skeptical view of the reforms, arguing in an op-ed that they will drive up both insurance premiums for patients and the country's overall debt.

As with all the changes that confront the U.S. health care system, some will be for the better and some will likely not. There will be perceived winners and losers. What remains unchanged is the biological fact that disease creates physical and emotional vulnerability, and those who are sick seek someone to help cure them if possible, and comfort them when that is the only course. Over the centuries, physicians have met this call by applying the art and science of medicine with the aim of improving health and reducing suffering. By keeping faith with this longstanding ethic, physicians and the medical profession will be in a better position to lead during these transformative times.

Virtual Mentor Editors

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CLINICAL CASE
Political Discussions in the Exam Room
Jack P. Freer, MD

Dr. Buccarelli is already behind schedule when he encounters his next patient, Mr. Van Ware. Mr. Van Ware is coming in for a follow-up appointment after a lingering, viral URI that finally resolved. He is politically engaged and has been following the Affordable Care Act legislation closely. His own insurance premiums have risen, and he asks what Dr. Buccarelli thinks of the individual mandate for health insurance.

"You think it's fair that a young, healthy guy like me should be shouldering the bill for chronic care for the elderly?" Mr. Van Ware asks. Dr. Buccarelli replies in a general way that the current health system has its flaws and he is just happy that legislators are attempting to address the problems. Unsatisfied, Mr. Van Ware repeats his question about young people subsidizing older people's expensive end-of-life care.

After a couple back-and-forths, in which Dr. Buccarelli politely explains that the ACA is 2,000 pages long and very complicated and that it will be years before the regulations are ironed out, Mr. Van Ware says, "Seriously, Doctor. You must know more about this new act than I do. Do you think the mandate that all of us, healthy or not, have to buy insurance is constitutional? Isn't it socialism?"

Dr. Buccarelli considers all the answers he can offer Mr. Van Ware (who seems to have forgotten that, young healthy man that he is, he has had a serious URI for several weeks). Dr. Buccarelli feels his clinician's role conflicting with his educator's role and, meantime, his waiting room continues to fill.

Commentary
Dr. Buccarelli's predicament is familiar to physicians who have spent any time in ambulatory clinical care. Falling behind schedule is annoying to patients and aggravating to doctors. Mr. Van Ware, with his resolving URI, ought to be an easy opportunity to catch up a little. Instead, patients often surprise us with unexpected symptoms or (as in this case) an urgent need to talk about current events.

Educating patients is an important part of practicing medicine. Aside from clinically relevant teaching that concerns the patient's own condition, physicians have a broader role to share their unique perspective and knowledge with the public. Certainly, physicians have an inside track about health policy and health care reform. And yet, Mr. Van Ware may not be asking for Dr. Buccarelli's opinion as much as he is grandstanding and debating an issue dear to his heart. He may be simply

broadcasting his opinion to a captive audience (an opinion that is unlikely to change, no matter what Dr. Buccarelli says). Having attempted a polite diversion, Dr. Buccarelli can either address the issue or unequivocally notify the patient that the discussion is over. Giving Mr. Van Ware the benefit of the doubt, it may be that he is truly interested in his physician's views. In that case, Dr. Buccarelli should have a few tight, informed comments to make about this important public policy issue directly related to medical practice.

Health insurance is a gamble, a bet. In a sense, you are betting that you *will* get sick or injured. If you "lose" the bet, you lose your wager (the insurance premium). If you "win" the bet, your payoff is that the cost of your medical care (or a very large part of it) is covered. Even young, healthy Mr. Van Ware can get hit by a dump truck running a stop sign later today and wind up being the recipient of several thousand dollars' worth of medical care before the month is out. Groups like the Amish recognize health insurance as gambling and reject it. Interestingly, the ACA contains a religious exemption [1]. Although not specified in the law, many feel that Anabaptists (Amish, Mennonites, Hutterites) and Muslims might qualify under this provision [2].

Emergency medical care is already provided to the uninsured, and the costs are shared by others in society. When Mr. Van Ware gets hit by that dump truck, he will be taken to a hospital and treated, regardless of whether he has insurance. The Emergency Medical Treatment and Active Labor Act, EMTALA, passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires hospitals to provide emergency care regardless of insurance coverage or ability to pay [3]. If Mr. Van Ware were given the choice to opt out of insurance coverage altogether, society would still share the cost of his care. Fortunately, we do not live in a society that allows uninsured people to die for lack of treatment. So, whether Mr. Van Ware realizes it or not, young, healthy, intact people *already pay* for the care of the old, sick, and injured. Costs are shifted to the government through taxes as well as higher insurance premiums across the board.

Universal coverage is more efficient and economical. In 2004, more than $40 billion in medical care to the uninsured was uncompensated [4]. The majority of this care was provided by hospitals. These losses are offset by government in the form of disproportionate share hospital (DSH) payments. Hospital care to the uninsured is fundamentally inefficient; it is emergency care, late in the course of an illness rather than preventive care earlier, when it is more effective. However one calculates the economic costs of caring for the uninsured (due to uncompensated, late, or forgone care), it is more than the cost of insuring them.

The current health care system is financially unsustainable. The American health care system has grown in unbridled fashion for years. Gaining control over this sprawling system is the first step in slowing and reversing cost escalation. Analysts may disagree about the best way to gain control. While not perfect, the ACA is expected to make a significant difference [5].

While physicians may want to have some prepared sound bites in response to common questions, they ought to have a deeper knowledge of some of the underlying issues. Clearly this issue is extraordinarily complex and the details can be mind-numbing. Still, there are some valuable resources that can be accessed easily through the Internet. The Henry J. Kaiser Family Foundation has prepared a number of excellent analyses of health care reform and financing issues [6, 7], the federal government has a useful website on the subject [8], and HealthCareAndYou.org is an authoritative site sponsored by several organizations, including AMA, AARP, AAFP, and ACP [9].

Finally, there is another issue that could arise in this situation. When people display strong opinions about social and political issues, there is often the potential for the discussion to become heated and personal. The doctor's office is no exception. In this setting, however, there is a real concern about professionalism and the patient-doctor relationship. Physicians must continually be aware of their place in relation to the patient. Ordinarily, the patient is not the doctor's buddy. In fact, preexisting friendships put considerable strain on a clinical relationship. When professional relationships get blurred with personal ties, both can suffer. The friendship can be strained when the patient is unhappy with the doctor's decision. Equally problematic is the way in which professional decision making can be compromised with a patient-friend. While not as striking as when caring for family members, the medical decisions made for friends can be similarly distorted.

When political discussions take a bad turn in a friendship, people can just drift away, but what about a patient-doctor relationship? Suppose you hear what sounds like racial bias (or even a blatant racial slur) in a political diatribe [10]. Does it affect your attitude toward that patient and can you objectively provide care for that person any longer? What does it say about how someone views *you* when he or she feels comfortable saying hateful things to you? Of course, a patient who resists more subtle suggestions that political debates or speeches are off limits, may need to be told directly that the professional relationship cannot continue without a limit on that behavior.

When both parties understand their roles, many aspects of the relationship can be presumed and go unsaid. In some situations, however, the terms must be explicitly restated. When that happens, honesty, transparency, and clarity are required to keep things on track.

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CLINICAL CASE
Physician Involvement with Politics—Obligation or Avocation?
Commentary by Thomas S. Huddle, MD, PhD, and Kristina L. Maletz, MD

Dr. Mills and Dr. Ribeira are having a conversation in the hospital break room. Dr. Mills is complaining about another physician, Dr. George, because Dr. George is heavily involved in lobbying his local congressman for patient-centered health reform.

"He'd be doing a lot more good," Dr. Mills suggests, "if he spent less time following politics and more time reading medical journals. In my opinion, the best way for physicians to provide quality care for their patients is to be competent, careful, compassionate, and spend their extra time learning about the latest treatment recommendations. Not only that," he adds, "George is so wrapped up in partisan politics, writing and arguing with his congressman. I don't see how he can remain unbiased and patient-centered in his practice."

Dr. Ribeira disagrees and, in fact, applauds Dr. George's patient advocacy, noting that if physicians don't contribute to an informed discussion of health reform, from whom should legislators obtain information? He expresses a belief that physicians have a duty to advocate for sound health policy. "The Dr. Marcus Welby days are over, my friend," he says to Dr. Mills. "We have a simple choice today: work to enact policy that will help medicine or have someone else force politically motivated regulations on us."

Commentary 1
by Thomas S. Huddle, MD, PhD
Dr. Mills finds fault with a colleague, and Dr. Ribeira defends him. As is perhaps typical of conversations in hospital break rooms, each is more concerned with expressing an opinion than with carefully articulating and defending a position. Dr. Mills is overly impatient with Dr. George. Dr. George's preoccupation with politics need not imply that he neglects the medical literature. Nor does his involvement with politics signify an improper influence affecting his medical practice. Many physicians pursue more or less absorbing avocations alongside professional work, and their professional work is unimpeded. Dr. Mills has offered no particular grounds for supposing that politics is interfering with Dr. George's practice. Medicine need not, and, likely, ought not to occupy the whole of any physician's life. Politics is but one of many possible avocations, but there is no reason to think that it is especially incompatible with medicine.

Dr. Ribeira might well take such a view. But his defense of Dr. George goes a step further, suggesting that physicians not only may engage in political advocacy but must do so. What Dr. Ribeira goes on to say does not, however, offer a compelling rationale for mandatory physician advocacy. In support of his position he proposes two possible physician approaches to politics. Physicians may either participate in politics and, thus, have some effect on medicine's political environment, or they may abstain and take the consequences. How does it follow from these alternatives that political participation is mandatory? If some physicians are content to take the bargain offered them by society, even if that bargain includes "politically motivated regulations," the more obvious conclusion would be that, if they eschew politics, they must remain content with that bargain.

Might there be a better case for mandatory physician political advocacy than that offered by Dr. Ribeira? Those who defend mandatory advocacy generally begin from the medical profession's obligations to society [1]. These obligations, we are told, imply that physicians must act to ensure universal access to health care and to further the health not only of individual patients but of the larger community. And the health of the community is in large part determined, of course, by factors that have little to do with patient care. Diet, exercise, levels of violence, and risky behaviors all play important roles in our collective health (or lack thereof). Individual physicians, accordingly, must do their part to bring about improvement in these social determinants of health. Such improvement can be achieved only through political action; political advocacy on behalf of health is therefore necessary [1].

As capsulized above, the argument for mandatory physician advocacy suggests a given content for the medical profession's normative commitments. Such an argument might be taken in two different ways: it might be contended that the commitments in question just *are* those held in common by the medical profession—so that we physicians must simply recognize what we are committed to and act accordingly—or it might be contended that these *ought* to be medicine's commitments, even if they are not at present. Taken either way, the argument fails.

Begin with the argument taken as an assertion about what medicine's normative commitments actually are, as physicians, in general, experience them. It is certainly true that medicine has obligations to society. It is simply false, as an empirical matter, that physicians experience these obligations as extending to advocacy either for universal access to care or for measures aimed at improving societal health, at least at present. While professional organizations and programmatic statements have called for the recognition of such obligations in the past 20 years or so, physicians have not so far taken such calls to heart. That is, physicians do not generally engage in political activity specifically related to health care access or health [2, 3]. And the medical profession historically has not enjoined them to do so. The move to graft these particular obligations onto the physician's professional persona is a recent one [4]. That being the case, it is difficult to maintain that an obligation to advocate is part of what physicians are committed to. Any such claim ignores the history of medical professionalism, in which these obligations simply do not figure.

What about the argument that these obligations *should* be part of our identity as physicians, even if they have not been so in the past? Such an argument will, of course, appeal to those physicians who have an affinity for seeking social improvement through politics. Such physicians make up a venerable strand in the tradition of the American medical profession. Public health, community medicine, and social medicine have always been important fields in our history, even if they have not attracted the numbers, energy, and funding that we now devote to biomedical research and clinical care [5]. Politically minded physicians will recognize, however, that their own fulfillment in particular nonclinical activities is not a knock-down argument for mandating the pursuit of those same activities by all physicians.

Those who favor mandatory physician advocacy contend that our goal as a profession is societal rather than merely individual health and that, because societal health cannot be achieved without political action, physicians must agitate for measures calculated to increase it. Even if this were granted, it would still remain to be shown why all rather than just some physicians should be politically active on behalf of health. We must, however, reject "the health of society" as the profession's mission, at least in so far as such a mission is taken to imply a norm directing our activity rather than an ideal to be favored, *ceteris paribus*. This seems a paradoxical admonition; it would be odd if physicians did not favor societal health. And, of course, as an ideal, they should and, doubtless, do favor it, just as they favor societal prosperity, the defense of society from its enemies, or any other desirable social outcome. But they ought not to be compelled to seek increasing societal health in the political arena. It might seem strange to contend that physicians need not strive for societal health in that way. But consider what is implied by a physician obligation to seek societal health through engagement in politics.

Marshalling the individual members of a profession in the pursuit of societal health through political means is to commit individual physicians not simply to the good health of their patients but to visions of the common good in which communal health is preferred to other goods when other goods compete with it. It is perhaps an obvious objection to any such proceeding to observe that physicians, while they clearly share common approaches to the ill health of their patients, do not, by virtue of that commonality, share a single conception of the common good, even to the extent of identifying a given priority for communal health. To suppose that they should is to posit the desirability not only of a common identity in approach to our work but in our political vision. It is to make of the medical profession by design a political movement on the societal stage. The medical profession has been more or less active in politics at various times in our history, but we have never before defined our profession's core mission in political terms.

Why ought we to resist the subsumption of medicine into politics as a means to the achievement of communal health? Because there is no single right answer to the question of how far we should devote our energies to attaining more communal health and fewer of other goods necessarily given up on the way to that goal.

Consider two political measures that physicians favoring societal health would be likely to advocate: mandatory use of child car seats and bans on cigarette smoking. These measures impose costs on driving parents and on cigarette smokers. Physicians can authoritatively pronounce on the gains in health and safety that result from such measures. They cannot similarly determine the relative value of those gains in comparison with the costs incurred by those who pay. The latter determinations are normative judgments that physicians make with no more authority than any other citizen. Physicians, through the nature of their work and their acquaintance with the harms of accidents and lung cancer, are likely to favor both the mandatory use of car seats and bans on smoking. Their opinions are not on that account dispositive, and physicians who happen to oppose either measure commit no professional sin.

Physicians may, in fact, prefer political quietism to activism and may prefer other goods to communal health on any and all occasions when political choices between health and other goods present themselves—even to the extent of opposing the mandatory use of car seats or smoking bans. They are none the worse as physicians and professionals for such preferences. That is to say, we are called upon as professionals to espouse and adhere to a common approach to our professional work. We are not called to decide upon a given vision of the good life and then to seek the imposition of that vision first on our own membership and then on society through the political process. That is what must inevitably be involved in making societal health part of our professional mission. We must resist the temptation to construe our mission in that way.

The impulse to make political activity integral to professional experience is an instance of a wider phenomenon: the impulse to expand the realm of politics into all of life, as if all of our personal, institutional, social, and economic relations must be made to serve a given political vision. Underlying arguments for mandatory physician advocacy is the wish to give a professional imprimatur to political goals that cannot otherwise speak with professional authority—and that do not warrant such authority. Such sleight of hand will not elevate our professional morality in the public eye; it will diminish it, as has happened recently in Wisconsin [6]. There are many reasons to seek to keep our work life separate (to the extent that we can) from the passions of politics—and from the duplicity and cynicism that too often accompany politics. Seeking a complete separation is doubtless unrealistic, but, on the other hand, we need not bring politics into the center of our professional identity as physicians—something it has never been before and ought not to be.

Of course many physicians, such as Dr. George, will be drawn into political activity on behalf of societal health. That is very right and proper; it would be odd if those physicians with political inclinations did not channel them toward political causes that drew from their daily experience. Dr. Mills is mistaken to find fault with Dr. George on account of his involvement in politics. If he has serious questions about Dr. George's care of his patients, he ought, in any case, to be bringing those questions either to Dr. George himself or to proper authorities rather than to whoever

happens to be in the hospital break room. But Dr. Ribeira goes too far in Dr. George's defense. What is right for Dr. George is not and ought not to be compulsory for all physicians.

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Commentary 2
by Kristina L. Maletz, MD

As this case shows, physicians today garner both respect and suspicion when involved in political affairs. A Gallup poll during the height of the health care reform debate showed a high degree of trust in physician involvement. Overall, the poll showed greater public trust in physicians' ideas for reform than in those of health care academicians, politicians, or commercial groups [1]. Almost three-quarters of Americans expressed confidence in physicians to do the right thing in changing the health care delivery system; only half as many felt that way about congressional leaders.

Physician advocacy is not a new concept. Throughout the history of modern medicine, physicians have acted as political advocates as well as clinicians and scientists. German physician Rudolph Virchow, often referred to as the father of modern pathology, is well remembered by various medical terms named after his work, including Virchow's Triad, Virchow's node, Virchow's psammoma, and Virchow-Robin spaces. In nineteenth-century Germany, Dr. Virchow also ran for and served in political office as a civic reformer, championing the reformation of sewer and water systems, because he recognized that disease did not exist as a pure biological phenomenon, in isolation from its surrounding social context. Noting the similarities between medicine and politics, he said:

> Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the answers for their actual solution…. The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction [2].

More recently, Dr. Herbert Abrams, a radiologist who received the Nobel Peace Prize for his work with the International Physicians for the Prevention of Nuclear War, termed physician activism "the fourth dimension of biomedicine." In addressing graduating medical students at Stanford University School of Medicine in 2007, he spoke of patient care, research, and teaching as the first three dimensions linked by physician activism to the greater outside world. "Activism," as he explained,

> means engagement, involvement, sharing a voice or an activity, individual or joint or cooperative action in an area of need…. It represents an understanding that there are areas beyond our professional work and achievements that link to urgent continental or planetary needs. It stems from the connectivity of all humans and the awareness of that great universal community in which hundreds of thousands of smaller ones coexist. It reflects a sense of values that derive partially from the Enlightenment and persist in religious and secular humanism over time [3].

Only 150 years after Virchow, it is unusual to see physicians engaging in political actions to the degree they once did. While 11 percent of the signers of the Declaration of Independence were physicians, only 1 percent of congressional leaders over the past 50 years have been [4].

The medical profession does not have a union to act on important issues. Instead, it relies on the volunteerism of individual physicians to either become politically active themselves or to electively join and contribute to organizations that will advocate on their behalf. But organizing is inherently challenging in such a tremendously diverse field. Medicine is made up of generalists and specialists, rural and urban practitioners, private and academic practices, small practice groups and large hospital staffs. Any single organization attempting to represent the medical profession as a whole needs to appeal to a multitude of different ideologies, backgrounds, and interests. Then it has the monumental task of identifying issues that a majority of members not only agree are important but also agree on what should be done. Consensus is hard to find, and physicians who care about an issue must often go it alone.

Physicians who engage in political advocacy face many obstacles. The time demands of maintaining a medical practice often prohibit political activity and activism. Physicians must keep abreast of growing amounts of clinical and scientific information, leaving little room for following political issues in depth. The unpredictability of a physician's schedule, dependent on the demands of patients, presents a challenge for meeting with equally busy political officials and staff members.

Some, like Dr. Mills, may have a general feeling that political activism is futile or even unethical. Often, political advocacy is associated with entrenched or extremely partisan views, but physician advocates need not—and should not—be close-minded, biased, or self-serving. Political advocacy is not the championing of one political party, one point of view or one profession. Political advocacy can be the potential leadership and collaboration with government to ensure that decisions and actions are made in the best interest of society.

The skills required for political advocacy are already important for our profession and the betterment of patient health. The ability to identify a problem, construct a legislative solution, work with others (in this case, legislators) to implement the solution and monitor for potential problems or improvements to the solution is as useful when performing an intubation as it is when writing to one's elected representatives. Both can lead to the saving of hundreds if not thousands of lives. As physicians, we have the ability to speak on behalf of our patients.

Advocacy may also be important for Dr. George himself. Political apathy in medicine may lead to depression and frustration with forces "beyond our control." Behavioral science has shown that the cumulative effect of chronic stress coupled with helplessness has negative effects on physical and emotional health. One can only suspect the cumulative toll of viewing the environment in which we practice medicine and the adverse forces against our patients' health as unchangeable. The consequence of this can be seen in physicians' growing dissatisfaction with their work. Advocacy provides an outlet for that desire to change things, ultimately improving the physician's sense of well-being and ability to care for patients with complex medical and social problems.

Physician advocacy has historically been of vital importance for the betterment of the medical profession and improvement in public health. Physicians are trained to both diagnose and treat disease. However, disease encompasses more than a series of biological sequelae, and the treatment requires more than prescriptions and procedures. Political advocacy provides physicians the opportunity to educate legislators on positive systemic interventions beyond the realm of encounters with individual patients. Ultimately, patients are the beneficiaries when physicians like Dr. George bring forth issues that adversely affect their health.

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CLINICAL CASE
New Guidelines for Cancer Screening in Older Patients
Commentary by Lisa M. Gangarosa, MD

Mr. Eckler visited his internist, Dr. Gresher, for his annual physical. At 77, Mr. Eckler was in remarkably good health. He reported some pain and stiffness in his fingers and hips, mostly "until I get up and going in the morning," but he was still active during the day. His blood pressure was normal for his age, and his heart and lungs sounded good. His weight was the same as it had been a year before. Following the exam, Dr. Gresher congratulated Mr. Eckler on his continued good health, asked whether he would be getting the flu vaccine that year, and began to talk about the routine lab work he was ordering.

"And I want to schedule a colonoscopy, Doc," Mr. Eckler interjected. Dr. Gresher reviewed his patient's record on the screen in front of him and saw that Mr. Eckler had had colonoscopies at ages 60 and 70, both of which had been clear. He explained to Mr. Eckler that, given his past good reports, no known history of colon cancer in his family, and his age, clinical guidelines did not recommend that he continue to undergo the procedure.

"Yeah, but this guy I meet for coffee every morning, Mike, his 50-year-old nephew just got diagnosed with colon cancer. Mike's very concerned, and his doctor is ordering a colonoscopy for him."

An internist with a large percentage of patients on Medicare, Dr. Gresher was well aware of the emphasis on comparative effectiveness research and the practice guidelines that were part of the medical records system the clinic used. He told Mr. Eckler that, for people of his age and with his prior colonoscopy results, the advantages of repeating the procedure did not seem to outweigh the risks.

"I'm more worried about colon cancer than about the test. I've had them before. It's not a big deal," Mr. Eckler said. "Mike and I agreed we'd drive each other to and from the test, like they advise. His is all set."

When Dr. Gresher repeated his concern about unnecessary testing of any sort, Mr. Eckler said, "I guess you're saying that it doesn't matter if I have colon cancer at my age. Is that what you're saying, Doc? Mike's going to have a clean bill of health, and I'm going to go on worrying. Maybe I should ask Mike's doctor to order me the test."

Commentary

In many competitive, service-oriented industries, the mantra "the customer is always right" is taught to service providers. Even though many would argue that the practice of medicine is a competitive, service-oriented industry, this mantra is not applicable to our medical profession. The patient-doctor relationship is not the same as the relationship between a car owner and an automotive repair expert. A doctor must strive to balance the four principles of medical ethics: respect for autonomy, beneficence, nonmaleficence, and justice.

Dr. Gresher is faced with trying to balance beneficence and nonmaleficence with respect for Mr. Eckler's autonomy. Just because something can be done doesn't always mean it should be done. As is often the case in the practice of medicine, there is no 100 percent right or wrong answer to this scenario. Guidelines are just that: guidelines. Decisions regarding patient care must be individualized based on knowledge of both the individual patient and the available evidence.

Colorectal cancer is the third most common cancer in both men and women in the United States, and the incidence doubles each decade between the ages of 40 and 80 [1]. As age increases, however, life expectancy decreases, which impacts the risk-benefit ratio of a screening program.

In 2008 the United States Preventative Services Task Force published updated guidelines on colorectal cancer (CRC) screening that for the first time included recommendations based on age [2]. The guidelines:

- recommend screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75.
- recommend against routine screening for colorectal cancer in adults age 76 to 85 years. There may be considerations that support colorectal cancer screening in an individual patient.
- recommend against screening for colorectal cancer in adults older than age 85 years.

Comorbidity must be considered when making recommendations about CRC screening with older patients. In a retrospective study of 404 VA patients over age 75 who underwent colonoscopy and were followed for 5 years, only 8 (2 percent) were diagnosed with colorectal cancer. The majority of patients passed away from other causes. Only age and severity of comorbidity were risk factors for death within 5 years of colonoscopy [3]. In a decision analysis study incorporating age, life expectancy, and comorbidities in Medicare patients eligible for screening colonoscopy (i.e., no colonoscopy in prior 10 years), the authors found that in men and women aged 75-79 with no comorbidities, the number of life years saved was 459 and 509, respectively, per 100,000 colonoscopies; among patients with 3 or more comorbidities, there was no benefit [4].

Complications of colonoscopy occur more frequently in elderly patients. In a recent review, the rate of composite adverse events (perforation, bleeding, cardiovascular or pulmonary complications) for patients over age 65 was 25.9 events per 1,000 colonoscopies, and in those over 80 it was 34.8 per 1,000 colonoscopies. These are much higher rates than published in the literature for colonoscopy in general. Patients over 65 have a 30 percent higher risk of perforation, which is the most serious complication of the procedure [5]. I recall a recent case in which a 79-year-old man with significant cardiac disease underwent a colonoscopy to evaluate anemia, sustained a sigmoid perforation in the setting of significant diverticular disease, and survived emergency surgery, but died within 24 hours of the surgery.

Unfortunately no screening test is 100 percent perfect. A retrospective Canadian study showed that, for those—like the patient in the case scenario—with a negative baseline colonoscopy, the risk of cancer was 45 percent lower than that of the general population 5 years after screening and 72 percent lower 10 years after screening [6]. Interval cancers have been reported in 0.3-0.9 percent of patients with adenomas who underwent polypectomy. However, in a recent study of 1,256 patients who had repeat colonoscopies 5 years after a negative baseline exam, no cancers were found on the second exam [7].

Paternalism is acting in patients' best interests despite their wishes. Dr. Gresher is exhibiting passive, nonacquiescent paternalism by not agreeing with his patient's choice to have something done [8]. Another approach to patient care is shared decision making. This involves rational deliberation to achieve a joint decision which "satisfies the best interest of the patient" [9]. Dr. Gresher should review the pertinent information regarding the risks and benefits of colonoscopy with Mr. Eckler and see if a mutual decision can be reached. Dr. Gresher will also need to point out that Medicare will only pay for a screening colonoscopy every 120 months, which may affect Mr. Eckler's desire to undergo one 84 months after his last.

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MEDICAL EDUCATION

Graduate Medical Education Financing and the Role of the Volunteer Educator

Thomas J. Nasca, MD

Imagine it is 2013. You find yourself in one of the three following scenarios.

Researcher-Educator

You are a salaried faculty member at a medical center associated with a medical school. Twenty percent of your salary comes from an NIH clinical research grant and 80 percent from clinical revenue that you generate through direct patient care in your specialty. You support the deficits in your research program through surplus on your clinical revenue. You are a senior member of the department and receive no direct support from institutional sources. You teach in the integrated physiology course and the Introduction to Clinical Medicine course; you have residents and fellows on your clinical service year-round and a fellow in your research laboratory.

Clinician-Educator

You are a volunteer faculty member in a community teaching hospital that is affiliated with the local medical school. You are in private practice and generate 100 percent of your salary from direct patient care in your specialty. You support the overhead of your clinical practice, including the salary of its employees, through revenue generated by your clinical care. You are a member of the faculty of the community teaching hospital's independently sponsored residency program, serve on its clinical competency committee, and have residents and medical students from the affiliated medical school.

Program Director

You are the residency program director in an academic medical center. Seventy percent of your compensation is from your clinical work and 30 percent from institutional sources. You provide direction to the administrative infrastructure of the program and to its academic and motivational leadership. Among your duties are chairing the clinical competency committee; overseeing the residency office; recruiting residents; organizing and overseeing the education and evaluation of residents, faculty, and the program; and sitting on the graduate medical education committee of the sponsoring institution. Although this consumes more than 50 percent of your time, the institution supports 30 percent of your compensation.

In 2013, Medicare reimbursement for GME is dramatically reduced. What should you do?

The three scenarios describe levels of faculty engagement in graduate medical education (GME) today in the United States. We are blessed with a range of faculty expertise and interest, from full-time clinicians, who are expert practitioners of the art, to clinician-scientists who create new knowledge to move the art forward. Faculty with this range of skill sets (practical users of knowledge to creators of new knowledge) engage in the third use of knowledge, its dissemination, by educating students, residents, and fellows, as well as patients and families. It is this last use of knowledge—dissemination to residents and fellows—that I would like to explore with you.

Why would these three faculty members continue working to disseminate knowledge to residents and fellows at a time when all their efforts are not rewarded with "mission-based" compensation? What compels each of these faculty members, from differing institutional environments and roles, to remain engaged in the GME efforts at their institutions? I believe that the answer to this question lies in the fundamental principles that have framed our understanding of medicine as a profession and their implications for us in a constantly changing world.

These principles originate in three key traditions. The first is the Hippocratic tradition, which views medicine as a moral enterprise and the physician as the pivotal moral agent in his relationship with each individual patient. This tradition begins with Aristotle, Hippocrates, and the aspiration to do and achieve "the good," which leads to a description of the key elements of physician practice. Justice, altruism, scientific knowledge, prudence or practical wisdom (phronesis or clinical judgment), honesty, integrity, charity, courage, and other virtues have their roots in the Greek tradition of the good. These concepts were further developed during the Middle Ages through exploration of the virtues by Aquinas and Maimonides, among others, and, in our era, placed in the modern context by Edmund Pellegrino and David Thomasma in their descriptions of the virtuous physician.

The second tradition starts with the evolution of medicine from a guild to a profession. The beginning of this transformation is ascribed to John Gregory in his *Lectures on the Duties and Qualifications of a Physician.* These were heavily influenced by David Hume's writings concerning human sympathy and Francis Bacon's work on scientific excellence. Thomas Percival is credited with synthesizing these elements into a conceptual framework for the profession of medicine in 1803. Subsequent efforts have further refined and molded these concepts in the context of medical practice, as the science and delivery of health care have evolved. Pivotal for this discussion is this tradition's insistence that professionalism requires each physician to demonstrate commitment to competency, altruism, and medicine as a public trust. Explicit in the notion of "medicine as a public trust" is the responsibility of the profession to produce the next generation of physicians to serve the public.

Finally, the third traditional underpinning of medicine is the justice-based equitable distribution of the "good" of health care in a society. Perhaps the most influential philosopher and political scientist in the modern era in the United States is John

Rawls. Rawls constructed a theoretical framework for a just democratic society, "justice as fairness," and described principles that should guide the creation of the institutions within it that would assure justice. Connecting his theoretical concept of justice as fairness to the practice of medicine are, among others, Madison Powers and Ruth Faden. These thinkers view the implementation of justice in the social context as society's responsibility to secure its citizens the opportunity to achieve a state of "well-being." They describe six elements of well-being: health, personal security, reasoning, respect, attachment, and self-determination. Physicians, in their day-to-day activities with patients, are engaged with three of these elements—health, personal security, and self-determination.

These three traditions form the fabric of professionalism as we know it in American medicine today. They both inform the content of the knowledge, skills, and art that we teach and set forth the expectations of the responsibility we voluntarily assumed when we recited the Hippocratic Oath, the Oath or Prayer of Maimonides, the Physician's Oath in the Declaration of Geneva, or other promises made at graduation from medical school. Pivotal in this "social contract" we all enter is the responsibility to treat the profession as a public trust.

This responsibility to maintain the profession as a public trust has a number of elements. The first is that we must practice medicine and configure our abilities to meet the needs that society has identified. While we have been granted the privilege of self-regulation in the United States by the public, we are expected to regulate ourselves in a fashion that assures that we meet the needs of the public, not our own needs. This is altruism in action at a professionwide level.

Second, we are responsible as a profession for the preparation of the next generation of physicians. This responsibility to assure the public that we prepare those who will replace us to meet future medical needs has been, at times, lost in the conversation about the roles and duties of physicians. This is especially true in the era of Medicare GME reimbursement, mission-based budgeting, and the regression of the profession toward guild status. I believe that our commitment to maintain the profession as a public trust compels us to assure a high-quality education of the next generation of physicians. Therefore, each of us bears some responsibility to share medical knowledge and clinical skills with those who follow us. This responsibility accrues to us independent of society's financial contribution to the effort.

I believe the profession has lost the sense of duty to educate over the past 15 or 20 years and assumed a posture of expecting compensation in return for sharing our knowledge with the next generation of physicians. This is the two-edged sword of Medicare reimbursement for GME and "mission-based" budgeting in our academic medical centers. That is, there are dollars provided to support not only resident salaries and fringe-benefit costs, but also for faculty supervision and teaching. It should be noted that, since the source of funding is limited to the Medicare program through its inpatient payment system, it only covers a fraction of the total costs of GME programs. Thus, even in the most educationally progressive institutions, GME

reimbursement to faculty for their educational and supervisory efforts fails to cover the costs in time and effort.

This is not a theoretical philosophical discussion in our current context. As this piece is being written, the United States, through its elected leadership, will determine whether GME funding by the federal government through the Medicare program will continue at the current level, be reduced, or perhaps eliminated completely. While one can make many compelling arguments why this is bad public policy, other exigencies may carry the day. Were significant reductions in GME reimbursement to occur, U.S. medical school faculty would need to contribute to GME by volunteering their time and expertise. Indeed, in certain circumstances, faculty clinical revenue generation may also have to provide a source of support for resident and fellow stipends.

It is reasonable to ask what the limit of altruism or voluntarism is in this circumstance. How much time and effort should, could, would we expect from members of the profession to fulfill its responsibility to the public to educate the next generation of physicians? Must every physician contribute in the same fashion, or to the same extent, in order to fulfill our commitment to medicine as a public trust?

Some of us are engaged directly in patient care, and the public trust is strengthened directly by the service we provide to our patients. In the modern context, that care should achieve the Institute of Medicine's aims of safety, quality, efficiency, and effectiveness. Those of us who have chosen careers that involve education must assure that we are effectively preparing the next generation of physicians. It is here, I believe, perhaps, that Aristotle provides us some insight. In his discussions of virtues, he points to the "golden mean" in the manifestation of virtue. Courage, for example, if manifested inadequately results in cowardice, at one extreme, and foolhardiness or recklessness at the other. Similarly, inadequate commitment to voluntarism could be viewed as selfishness, and too much voluntarism could interfere with obligations to a clinical practice and family. Whether we are clinician-scientists, volunteer clinician-educators, or residency program directors, each of us has a responsibility to uphold elements of the public trust that is medicine. We as professionals are responsible for finding a way to educate the next generation of physicians to serve the public, regardless of the nature and magnitude of Medicare GME reimbursement.

It will not be easy. But, then, medicine never has been easy. Each of the three physicians in the introductory scenarios must evaluate his or her ability and responsibility in light of individual professional commitment to the public trust. I suggest that they might consider the following elements, which I posit are required for the profession to maintain the public trust to educate the next generation of physicians.

First, each of us must identify that knowledge, those skills and abilities, and share them with those who follow in the settings in which we practice our art. We should

seek an Aristotelian golden mean, assuring that high-quality, safe care for our patients is preeminent and that the realities of personal economic survival are managed.

Second, we must have the courage to advocate for the needs of our patients and our trainees. This includes advocacy by both individuals and our professional organizations for societal support for the education of the next generation of physicians to serve the public.

Third, those of us in administrative roles must be mindful of the real costs to our faculty when asking them to share their gifts. We must structure our clinical educational programs to optimize the use of the time of the faculty and trainees. We should acknowledge, celebrate, and reward through recognition and other measures the talent and excellence of the faculty.

Fourth, those of us in leadership roles must reexamine the self-regulatory rules that we have imposed on our educational systems to assure that they are cost-effective and that they permit innovation and creativity within reasonable structure, process, and outcome requirements. This must all the while be accomplished in a fashion that assures the public that the common good, rather than our individual or collective needs, is the goal of our efforts.

Finally, we should all reflect on the promise we made voluntarily to the public to accept a life of service. By satisfying that promise to fulfill the public trust regardless of the nature and magnitude of public support for our educational efforts, we demonstrate the meaning of that promise.

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THE CODE SAYS
The American Medical Association *Code of Medical Ethics*' Opinion on Pay-for-Performance Programs and Patients' Interests

Opinion 8.056 - Physician Pay-for-Performance Programs
Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:

(a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;

(b) program flexibility that allows physicians to accommodate the varying needs of individual patients;

(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;

(d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:

(a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;

(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;

(c) be aware of evidence-based practice guidelines and the findings upon which they are based;

(d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;

(e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients.
Report: Issued June 2006 based on the report "Physician Pay-for-Performance Programs," adopted November 2005 (Indiana Health Law Review. 2006;3(2):421-37).

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JOURNAL DISCUSSION
The Effects of Congressional Budget Reconciliation on Health Care Reform
Eugene B. Cone

Joyce PG. Congressional budget reform: the unanticipated implications for federal policy making. *Public Adm Rev*. 1996;56(4):317-325.

As we approach the 2012 congressional elections, there are few issues more polarizing than federal spending. It is perhaps surprising then, that the process with which federal spending is determined, remains relatively unfamiliar to many Americans. In the article "Congressional Budget Reform: The Unanticipated Implications for Federal Policy Making," Joyce examines the evolution of the congressional budget process, revealing several profound and unintended consequences of changes to the rules governing the process [1]. These changes played a crucial role in shaping the Patient Protection and Affordable Care Act of 2010.

In the article, Joyce inspects three underappreciated aspects of budget reform. He begins with a discussion of the importance of the introduction of the budget reconciliation process in the 1974 Congressional Budget and Impoundment Act. Second, he contrasts the originally politically-neutral process to its current politicized form, focusing on the impact of Gramm-Rudman-Hollings in 1985 and the Budget Enforcement Act in 1990. Third, he examines the increasingly common use of short-term fiscal "scorekeeping" as a substitute for long-term economic considerations.

The 1974 Congressional Budget and Impoundment Act
For the first several hundred years of U.S. history, the federal budget was a poorly defined and opaquely created entity [2]. In 1921, the Budget and Accounting Act introduced the previously unheard-of requirement that the executive branch submit a unified budget to Congress annually. Although a monumental addition of responsibility (and power) to the presidency, the act did not much change the state of affairs on the congressional side, and budgets submitted by the president were considered and voted on piecemeal by the various committees who claimed responsibility for individual provisions within. Further adding to the confusion, the president could refuse to spend congressionally appropriated money on programs he did not agree with, a power known as impoundment.

Some members of Congress agreed that failing to consider the budget as a whole made keeping track of total expenditures and balance impossible. It was not until President Nixon began using his power of impoundment at previously unseen levels

that Congress decided to overhaul the budget process. With the passage of the Congressional Budget and Impoundment Control Act of 1974, Congress created a politically neutral process, cleared of the usual parliamentary roadblocks such as supermajority requirements for points of order. They also specifically denied the president the right of impoundment [3].

The 1974 Budget Enforcement Act (BEA) also created the process of reconciliation. In broad strokes, reconciliation is a process through which members of the congressional chamber that originally passes a bill (the Senate, for example) may vote on changes made to their bill while it was being debated in the other chamber. The reconciliation bill (the vote by the Senate on the bill first passed in the Senate and then modified in the House) is subject to limited amendments and no more than 20 hours of debate before an up or down vote must be undertaken [4].

The original framers of the 1974 BEA did not anticipate that the reconciliation process would be particularly important except to accommodate specific economic or legal changes since passage of the first bill [5]. This proved to be incorrect. Concerned with the fate of his budget in Congress, President Reagan used large spending cuts in the first passage of the budget as proof that large tax cuts were indeed affordable and should be added into the budget via reconciliation and subjected to a single up or down vote. Although the tax cuts were not eventually enacted through reconciliation, Pandora's box had been opened.

Reconciliation is so politically potent because it allows for the consideration of legislative actions on a two-part basis. The initial vote on a budget is fraught with parliamentary obstacles and can easily be held up by the minority party. With reconciliation, the party in power can pass a budget with favorable terms for the minority party (spending cuts, for example), with the express understanding that the majority party's *quid pro quo* items will be added in during reconciliation (tax cuts to match the spending cuts). This communicates to both politicians and the public they serve that the budget is being considered as part of the larger picture.

The Politicization of the Process

The budget process created in 1974 could be used to increase or decrease spending and deficits, making it truly politically neutral (meaning it doesn't particularly encourage limiting or increasing either one). In 1985, amid fears of an expanding deficit, Gramm-Rudman-Hollings (GRH) created a series of automatic spending cuts (known as sequesters) that would be triggered if deficits exceeded fixed targets. This allowed for political blame-shifting, for when cuts or new taxes occurred that were objectionable to voters, a congressman now had the excuse that the law mandated the changes. It also created a political, although generally inoffensive, slant to the budget process, encouraging Congress to limit deficits. Lastly, by only including sequesters on spending (and not, for example, by mandating increased taxes), GRH implied a ceiling on congressional expenditures [2, 6].

Challenges to the constitutionality of the sequesters proposed in GRH resulted in several reworkings of the law, eventually resulting in the Budget Enforcement Act (BEA) of 1990. This BEA eliminated annual deficit targets and limited spending. The most important change was the creation of Pay As You Go (PAYGO), which mandated that any tax or spending changes were deficit neutral for the next five years. The Congressional Budget Office (CBO) increased monumentally in importance, as suddenly their projection of costs determined whether a new bill could pass muster with the BEA [1].

Enforcement and Short-Term "Scorekeeping"

The passage of Gramm-Rudman-Hollings and the Budget Enforcement Act of 1990 made cost estimation and the question of how a bill will be funded vital. President Clinton, for example, included caps on insurance premiums in his health plan not because he agreed with them but because they would decrease the cost projections of the CBO. Similarly, a 1994 trade agreement forced the Senate to waive its rules because the decreased tariffs in pursuit of free trade would unacceptably decrease revenues [1].

This emphasis on 5-year deficit neutrality, however, creates an extremely narrow focus. Health care reform has implications extending beyond congressional spending for 5 years, including long-term effects on national health and the economy as a whole. In Joyce's opinion, focusing on a bill's impact on deficits for half a decade is simply the wrong question. Further, by limiting the timeline, the creators of PAYGO ensured that the system could be duped with accounting tricks and the pushing of costs beyond the five-year enforcement window. The CBO does on occasion attempt to answer broader questions, including the 10- or 20-year costs of bills (most recently with health care reform), but these projections are not scorable, and therefore carry little political weight [1].

Implications for Current Policy Making

Joyce's article makes great strides in clarifying the political forces that influence the budget. It is worth noting that it was published in 1996, however, and that much has occurred since then. Pay As You Go was extended several times before expiring at the end of 2002. Accompanying this, a federal surplus of $128.2 billion in 2001 dwindled to a deficit of $377.6 billion in 2003 [7], largely due to the institution of Medicare prescription drug benefits and the 2003 Bush tax cuts, neither of which would have been permissible under PAYGO. The 110th Congress briefly resurrected PAYGO in Jan 2007 [8] but it has been waived a number of times for a variety of reasons including reforming the Alternative Minimum Tax (2007), updating farm subsidies (2008), and passing multiple economic stimulus plans (2008, 2009), among others [9-12]. Congress, it has been made clear, does not well tolerate limits on its spending capacity.

Unlike the easily circumvented Pay As You Go rules, reconciliation remains one of the most potent tools available to today's legislators. Since the Reagan era, however,

reconciliation has been used to pass omnibus spending bills, tax reform bills, and the Bush tax cuts in 2001 and 2003.

The Health Care and Education Reconciliation Act of 2010 (HCERA) was passed using reconciliation to bring the Patient Protection and Affordable Care Act (ACA) into its current form [13]. The idea of using the budget reconciliation process to pass health reform was discussed soon after President Obama took office and green-lighted after the Democrats lost their filibuster-proof Senate with the death of Massachusetts Senator Ted Kennedy and the election of Senator Scott Brown to replace him [14, 15]. The Senate approved the ACA in December 2009, and the House was strongly encouraged to pass this legislation in early 2010 because its ratified version, the Affordable Health Care for America Act, faced an almost certain filibuster in the Senate [16, 17].

In March, the House passed the ACA, but Congress used the budget reconciliation process to add amendments to the bill and prevent filibusters in the Senate in the process. By March 25, 2010, both chambers of Congress approved HCERA, which, among other things, altered the penalty for not buying insurance, closed the Medicare "doughnut hole," delayed and lessened the tax on high-end insurance plans while expanding the number of plans that will eventually be affected, and altered higher education assistance financing [18].

President Obama signed the bill into law on March 30, 2010, achieving two goals set during his election campaign, health reform and improving higher education assistance. The CBO estimated that this legislation will reduce the federal budget by $143 billion over 10 years, providing coverage for an additional 32 million people, and requiring more Americans to have health insurance [16].

CBO's scoring of HCERA has been disputed, and this bill has been considered a factor in the Republican party's major victories in the 2010 elections, which resulted in their majority in the House [19]. Beginning early in the 112th Congress, the Republican-controlled House passed their repeal of health reform, The Repealing the Job-Killing Health Care Law Act (HR 2). The Senate took up this bill but it was quickly defeated [17].

The congressional budget may only intrude on the public psyche during election season when it appears in countless sound bites, but it is of vital importance to the country. Although the budget is submitted by the president, and despite recent analysis indicating that the president's party affiliation may be the most important determinant of where the money flows [20], it is in the halls of Congress that the budget takes its final shape. Joyce describes in his article how relatively small changes in the rules governing the budget process have had far-reaching implications. As the budget process is reformed and the rules surrounding filibuster and congressional procedure are revised, it would be wise to remember his point.

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JOURNAL DISCUSSION
The Physician Group Practice Demonstration—A Valuable Model for ACOs?
Todd Ferguson, PhD

Iglehart JK. Assessing an ACO prototype—Medicare's Physician Group Practice demonstration. *N Engl J Med*. 2011;364(3):198-200.

Wilensky GR. Lessons from the Physician Group Practice Demonstration—a sobering reflection. *N Engl J Med*. September 14, 2011. [Epub ahead of print]

In August 2011 the Centers for Medicare and Medicaid Services (CMS) released findings from its Physician Group Practice (PGP) Demonstration, "a landmark partnership with physician group practices that aims to better coordinate care across different settings, leading to improved quality and cost savings" [1]. At the end of the 5-year project, CMS announced that the demonstration showed such "significant progress in areas of both quality improvement and savings in Medicare expenditures" that it has extended the original program into a 2-year supplementary transition demonstration [1].

Medicare's first pay-for-performance initiative launched in 2005 with 10 PGPs and was designed to help coordinate Part A and Part B Medicare services, "promote cost efficiency and effectiveness through investment in care management programs," and "reward physicians for improving health outcomes" [2]. The key point of the demonstration is that physicians still received their Medicare payments but also had the opportunity to receive additional performance payments if they generated savings and satisfied benchmarks on 32 quality measures. According to CMS Administrator Donald M. Berwick, the PGP demonstration "provide[s] great insight into how to use Medicare's payment systems to improve quality while reducing costs" [1]. There is some disagreement, however, over the promise of the PGP demonstration to lead to greater savings and to what degree it should serve as a model for accountable care organizations (ACOs).

In her recent article, "Lessons from the Physician Group Practice Demonstration—A Sobering Reflection," Gail Wilensky argues that the overall results of the PGP Demonstration project are cause for some concern [3]. After providing a brief overview of the demonstration and discussing some of the (limited) benefits of the project, Wilensky questions whether it generates enough savings to serve as a viable cost-cutting model for ACOs going forward. The "good news" about the project is that it did "very well" in meeting or exceeding nearly all of the 32 quality goals, which assessed performance and quality measures in areas like preventive care, diabetes mellitus, coronary artery disease, and hypertension [3]. But while these

results might be "worth applauding," Wilensky believes they are overshadowed by the fairly unremarkable savings generated by the PGP participants.

For example, after the first year of the demonstration only two PGPs managed to exceed the 2 percent savings benchmark, and only half of them did so after 3 years [3]. According to Wilensky, such meager savings do not bode well for ACOs, which will also have a 2 percent saving threshold but "will have to meet benchmark levels on an even larger set of quality metrics than the PGPs did" [3]. Essentially, Wilensky's concern is that, if the 10 practice groups selected for the demonstration had such difficulties improving the quality of health care services while also improving cost efficiency (e.g., exceeding the 2 percent savings threshold), how could this serve as an effective model, on a much larger scale, for ACOs? Wilensky remains skeptical that ACOs, as they are currently envisioned by the CMS, will be a "viable alternative to both traditional Medicare and traditional managed care" that can "encourag[e] newly formed groups to provide care in ways that can both improve quality and reduce costs" [4].

While Wilensky takes the pessimistic glass-half-empty approach to modeling ACOs on the PGP demonstration, others are more optimistic. Donald Berwick, for instance, believes that the ACO model will benefit from the PGP demonstration because it:

> helped to identify several factors that are critical to improving quality and increasing the opportunities for shared savings: an integrated organization that supports expending resources on programs to improve quality and reduce the provision of unnecessary services; dedicated physician leadership with a proven ability to motivate the implementation of quality-improvement programs; and a central role for health information technology in enabling the organization to manage population health and receive feedback at the point of care [5].

But while such lessons can be gleaned from the PGP demonstration and applied to the long-term implementation of an ACO model, the key issue is identifying what else can be done in the meantime to help curb Medicare spending. CMS is currently scheduled to launch the ACO program in January 2012, but it is unclear how long it will take for ACOs to show that they are successful in reducing Medicare spending. As John Iglehart opines in his article, "Assessing an ACO Prototype—Medicare's Physician Group Practice Demonstration," the "ACO model is a work in progress, and the CMS must address many questions in crafting the new program's regulations" [6].

Overall, Iglehart views the demonstration as a successful model for reforming Medicare—based on the limited data of the 10 PGPs, the project showed promising results in improving the quality of care while generating cost savings. Iglehart's worry, however, is that Congress will need to act to implement some type of stopgap measure to help increase Medicare savings before it is clear whether or not ACOs

can be as effective as the PGP demonstration in improving care and reducing overall costs [6]. It is simply not enough to have faith that ACOs will single-handedly solve Medicare's ongoing financial crisis.

The current debate about the future of Medicare only promises to turn more contentious as discussions about the sustainable growth rate become more urgent, as CMS announces its final rule on ACOs, and as health systems across the country begin to spend more time and money preparing to transition to the ACO model by January 2012. As Donald Berwick comments, "accountable care is not panacea" for reforming Medicare but is "one of a number of complementary initiatives chartered by the ACA [Accountable Care Act] to help achieve the three-part goal of lower costs, improved care, and better health" [5]. What remains to be seen, however, is just how these "complementary initiatives" can work in concert to help make Medicare an effective, efficient, and sustainable program. It is up to the government and health care systems throughout the country to make it happen.

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HEALTH LAW

Constitutional Challenges to the Patient Protection and Affordable Care Act—A Snapshot

Lizz Esfeld and Allan Loup

Debates about the Patient Protection and Affordable Care Act of 2010 (ACA) and its measures continue to play out in both the court of public opinion and our federal and state courts. Various federal courts, called circuit courts, have reached different decisions on whether the act is constitutional. Recently, the Department of Justice petitioned the U.S. Supreme Court for review of the conflicting decisions, making it very likely that the Supreme Court will make a final decision by June 2012 [1].

The question of constitutionality has mainly focused on the act's "minimum essential coverage provision," which requires that individuals maintain a minimum level of health insurance coverage starting in 2013 [2]. Central to this debate is whether Congress has the constitutional authority to require all American citizens to maintain minimum insurance coverage.

What is the Minimum Essential Coverage Provision?

The provision requires that every citizen of the United States, except those falling within specified exceptions, acquire and maintain a minimum level of health care coverage [2]. Exceptions include those exercising religious conscience, those who cannot afford coverage, and those who, by reason of low income, do not file taxes [2, 3]. Failure to obtain minimum coverage by anyone else will result in a tax penalty [3].

ACA proponents stress that this provision is important to the overall legislation, mainly for financial reasons. One section of the ACA requires insurers to provide coverage for people with preexisting conditions [4]. This mandate will likely increase costs to health care insurers because they will be providing coverage to more sick people, thus driving up costs for everyone. Mandating that everyone take part in health insurance will widen the pool; more healthy people will be paying premiums while needing little medical care, thus counterbalancing the cost to insurers of covering sick people [5]. Moreover, requiring everyone to purchase health insurance might reduce the total costs of treatment for patients with preexisting conditions by providing them access to care earlier in the development of those conditions, as well as preventing "free riders," those who join up last-minute and receive care but have paid little or nothing into the health plan [6]. For reasons such as these, ACA proponents insist that the minimum essential coverage provision is not only appropriate but also crucial to fulfilling the greater purposes of the act.

What is the Commerce Clause?
Broadly speaking, Congress's powers must be granted to it by the Constitution. All other authority is reserved for the states. One of the powers granted to Congress by the Constitution is the ability to pass legislation regulating "Commerce with foreign Nations, and among the several States, and with the Indian Tribes" [7]. The commerce clause has been interpreted to give Congress the power to regulate (a) any item that travels in interstate commerce (such as goods transported across state lines), and (b) any action that, when taken in the aggregate, can substantially affect interstate commerce [8]. The "substantial effects" test has, in the past, given the federal government a wide reach in regulating the national economy.

For example, in *Wickard v. Filburn* Congress attempted to regulate the price of wheat by limiting how much wheat farmers could grow and sell [9]. The plaintiff in that case grew wheat in excess of the limit and used it to feed his livestock [10]. He argued that Congress could not prohibit him from doing so because the wheat never moved into the stream of interstate commerce [11]. The Supreme Court ruled that, even though some of his wheat was purely for personal use, the regulation was constitutional because, if all farmers acted as the plaintiff did, those actions would, in aggregate, have a substantial effect on interstate commerce [12]. More farmers would not need to purchase wheat on the market, thus decreasing demand and lowering the market price of wheat. And, in turn, it would undermine Congress's ability to effectively regulate wheat prices, which is a reasonable goal for Congress.

The question addressed by the federal courts when looking at ACA is: can Congress require someone who might not otherwise do so to purchase health insurance, or is that power outside the reach of the Constitution? To date, four of the thirteen circuit courts have heard the case and come to different decisions. The Third and Fourth Circuit courts have failed to reach a verdict regarding constitutionality because they believed the parties had no standing (or right) to bring the lawsuit before the courts [13, 14]. The other two courts have diverged in their rulings, with the Sixth Circuit finding the essential coverage provision constitutional, and the Eleventh Circuit finding the opposite [15, 16].

The Sixth Circuit
The Sixth Circuit—which has jurisdiction over Michigan, Ohio, Kentucky, and Tennessee—ruled that the minimum essential coverage provision falls within the powers of Congress and the commerce clause and is constitutional [15]. This decision relies on the theory, developed in the *Wickard* case, that Congress may regulate acts that, in the aggregate, substantially affect interstate commerce [17]. The Sixth Circuit sees all citizens as being actively involved in the health care market: they participate in the health care market either by purchasing insurance, by paying for medical costs out of pocket, or by incurring costs they do not cover [18]. Like the wheat farmer in *Wickard* who grew his own wheat and thus potentially affected the overall market for wheat, uninsured individuals also affect the market price of a good or service they choose not to purchase [18]. In this way, the Sixth Circuit sees those

who are not currently purchasing health insurance not as being removed from the market, but as still participating in the market, albeit in a different manner.

The Sixth Circuit distinguishes the health care market from other markets that Congress might be tempted to regulate in the same manner by pointing out its uniqueness. Hospitals are required to provide certain health care to patients whether or not an individual is capable of paying for it. This distinguishes it from the markets for food and clothing, which seem just as essential, and yet no store is required to provide them for free [19]. This unique aspect of health care delivery causes the cost of health care for the insured to rise to meet the burden of providing care to the uninsured, thus making this a more appropriate issue for Congress to regulate than some other forms of commerce [19].

The Eleventh Circuit

The Eleventh Circuit—which has jurisdiction over Alabama, Florida, and Georgia—ruled that the individual mandate was unconstitutional and distinguished the case from *Wickard* in two ways [16]. First, the court elaborates that, in *Wickard*, Congress foreclosed only one of many options for wheat growers, unlike ACA, with which Congress mandates a certain action from consumers and eliminates other choices [20]. In *Wickard*, the wheat grower "could have decided to make do with the amount of wheat he was allowed to grow. He could have redirected his efforts to agricultural endeavors that required less wheat….[Congress] left [the farmer] with a choice. [ACA]'s economic mandate to purchase insurance, on the contrary, leaves no choice and is more far-reaching" [21]. The court has refused to make what it perceived would be a fundamental expansion of congressional power—Congress being allowed to dictate where and when Americans spend their money by forcing them to purchase health insurance. The court might fear this expansion would allow Congress to legislate that Americans must purchase other goods or services in order to regulate markets.

Second, the Eleventh Circuit argued that the minimum essential coverage provision attempts to regulate theoretical future economic activity (future receipt of health care) rather than ongoing activity such as growing and using wheat [22]. Congress assumes that everyone eventually will receive health care. The Eleventh Circuit responds that it is entirely possible for someone to never enter the health care market by never using medical services—but that this provision still attempts to regulate such people and force them into the health care market [22]. The court adds that receipt of health care is far less inevitable than participation in markets for basic necessities such as food and clothing [23].

The Eleventh Circuit further distinguished ACA by noting that the government has traditionally only been able to compel activities that concern citizens' relationships with the state itself. Historically, Americans have had few requirements of citizenship: serving on juries, registering for the draft, filing taxes, and responding to the census among them [24]. While these requirements involve the relationship

between citizens and the government, the minimum essential coverage provision regulates a relationship between citizens and private insurers.

The Third and Fourth Circuits

Both the Third (Pennsylvania, New Jersey, and Delaware) and Fourth (Maryland, Virginia, North Carolina, and South Carolina) Circuit Courts have ruled that, in some way, the plaintiffs bringing the case did not have a right to do so and, thus, the court need not reach a decision on the constitutionality of the law [13, 14]. The Third Circuit refused to rule on constitutionality because the persons challenging the law (a group of patients and physicians) could not prove how they had actually yet been harmed by the law [13]. Most recently, the Fourth Circuit argued that a state cannot bring a suit because the mandate affects individuals, not governments [14]. Moreover, this court believed that the individual mandate is a tax and thus cannot be litigated until the measure actually goes into force, under certain federal laws [14]. The issue of whether the constitutionality of the individual mandate is a matter of tax law or commerce clause law could be another key issue the Supreme Court will have to wrestle with in the near future.

Conclusion: The Road Ahead for ACA

If and when the Supreme Court decides on the ACA's constitutionality, the outcome may turn on a number of questions: Is Congress's right to require the individual mandate regulated by tax or commerce laws, or is it not permitted at all? Are all citizens inherently participating in the health care market? Would this legislation set a new precedent for congressional power over consumers, and, if so, what kind? And how does health care compare to other types of goods and services that the federal government regulates? The Supreme Court, if it grants *certiorari*—meaning that it has determined the subject is worthy of its review—would then also face the question of whether the minimum essential coverage provision could be severed from the rest of the ACA and struck down on its own [24]. If it cannot be severed, the whole of the ACA would be declared unconstitutional.

In the end, the present issue will only be resolved by a ruling from the Supreme Court—but even that, depending on the outcome, might be only a temporary resolution of the broader national debate.

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POLICY FORUM

Maine's Medical Liability Demonstration Project—Linking Practice Guidelines to Liability Protection

Gordon H. Smith, JD

In 1990, Maine enacted legislation to test whether the practice of defensive medicine could be reduced by providing protection to physicians who complied with guidelines established by their peers and national specialty organizations. The law provided that physicians who participated in the project could use adherence to the guidelines and protocols as an affirmative defense in a medical malpractice lawsuit. More than four hundred physicians elected to participate. Between 1990 and 1992, 19 practice parameters for the medical specialties of obstetrics and gynecology, radiology, anesthesiology, and emergency medicine were developed by medical specialty advisory committees comprising physicians, insurers, allied health professionals, and patients. The law was a joint project of the Maine Medical Association (MMA), the Maine Board of Licensure in Medicine, the Maine Bureau of Insurance, and the Maine legislature, and it had the support of the relevant medical specialty societies.

The project was eventually extended to 8 years, but was allowed to expire by the year 2000 when supporters of the law concluded that the affirmative defense intended to assist physicians had not been used in a single case in court. The purpose of this article is to explain the project and to explore the reasons for its enactment and its eventual demise.

The reasons physicians and legislators were interested in the idea of linking practice guidelines to liability protection will sound familiar. The 1980s had seen dramatic increases in both liability claims and premiums nationwide, and Maine was no exception. And the cost of health insurance was increasing as well, partly because physicians were practicing more defensively, ordering more tests and procedures than were medically necessary in an effort to protect themselves against potential liability claims. The Maine legislature also had considerable experience with the medical malpractice issue, having enacted three previous rounds of tort reform legislation, including, in 1987, the law establishing pretrial medical malpractice screening panels, which have proven very helpful in the state over the past 25 years. Much of the legislation has been supported by all the interested parties, including the Maine Trial Lawyers Association. Maine is a small state, and we all try to get along the best we can.

The four specialties were chosen because their state specialty organizations expressed interest and they had well-established national guidelines. The radiologists

were interested in field-testing new standards developed by the American College of Radiology, which the project would allow them to do. Emergency medicine was chosen because it was believed to be one in which more testing was going on than was arguably in the best interest of either patients or the public. The American Congress of Obstetricians and Gynecologists and the American Society of Anesthesiologists had well-established national guidelines that made those specialties natural fits for the project.

The proposed legislation included a provision that the project would not begin in a specialty without the active support of at least one-half of its members in the state. Despite the opposition of some (including, unfortunately, a number of prominent defense attorneys), we surpassed the 50 percent threshold in each of the specialties. Specialists determined which existing guidelines would be put into the project. This was a critical phase, as the legislation provided that the specialists would develop the guidelines but that the Board of Licensure in Medicine would then propose the guidelines as state regulations, thus ensuring that they would have the force of law if compliance with them were asserted as an affirmative defense. Nineteen guidelines were eventually selected by the physicians, and, in each case, the licensing board proposed and adopted the guidelines as board regulations. The adopted guidelines borrowed liberally from the standards enacted by national organizations such as the American Society of Anesthesiologists and the American College of Obstetrics and Gynecology and the underwriting guidelines utilized by the state's largest medical liability carrier, Medical Mutual Insurance Company of Maine.

It should be noted that the establishment of the guidelines as rules did not mandate that a specialist adhere to the guideline, as the legislation provided that adherence to the guideline could be asserted by a participating specialist as an affirmative defense, but that failure to abide by the guideline *could not be used against the physician* unless the physician introduced the guideline as an affirmative defense. It was probably this provision, more than any other, that led trial attorneys to oppose the bill.

Four standards were selected for anesthesia, two for emergency medicine, four for radiology, and nine for ob-gyn. The major goal of the project (reducing defensive medicine) may be best demonstrated by the protocol adopted by the emergency physicians regarding the use of cervical spine x-rays. Assume a victim of a motor vehicle accident who is brought to the ER by ambulance arrives completely immobilized on a back board. In the vast majority of instances, the treating physician, fearing the legal consequences, will obtain complete cervical spine films before moving the cervical collar, regardless of the clinical findings. Adequate studies have shown, however, that, in the absence of neck pain or neurologic signs in the conscious patient, the likelihood of a cervical fracture is virtually nil and therefore x-rays are not necessary. The practice guideline for emergency physicians defines the indications for cervical spine films based upon these scientific observations and provides the physician with the protection he or she needs to make the appropriate clinical decision without fear of litigation [1].

As noted above, the practice guidelines, once made into rules by the Board of Licensure in Medicine, had the full force and effect of state law. The rules became effective on January 1, 1992 and established the legal standard of care for malpractice claims based on actions occurring after that date. For better or for worse, for the next 8 years, not a single case was filed in Maine courts in which a physician used the affirmative defense.

Perhaps the proverbial handwriting was on the wall during the discussions leading up to the project. For an article in *The Quality Letter* in October of 1995, I was asked whether there was anything I knew then that I wish I had known in 1990 when the law went into effect. Here are the first two paragraphs of my answer at that time:

> I'm much more skeptical about our ability to use this methodology in actual litigation. It's going to take several court cases and judges looking at the law—not to mention lawyers willing to use the law—before we can really say that we've protected physicians from malpractice charges.
>
> To date, we haven't had a case in which this defense has been used, which is why the legislature recently extended the law for three years. But we've known from the outset that lawyers here had misgivings about the project. Their suspicions are beginning to look like self-fulfilling prophecy. This bothers me because it's the defense lawyer and the insurance company—not the doctor—who will decide whether the affirmative defense is ever used [2].

Defense lawyers had been up front during the initial discussions with the concern that it would not be possible to draft protocols that were broad enough to be accepted by the profession but narrow enough to capture a fact pattern in a specific medical liability case. In addition, there was genuine fear on the part of the defense bar that a defendant-physician's image before the jury might be tarnished by a cookbook or checklist image of medical care, in contrast to the traditional approach of portraying the defendant as a caring and thoughtful practitioner applying his or her wealth of clinical knowledge as well as he or she could under difficult circumstances. (And it is no secret that defense attorneys are conservative by nature. They are not inclined to try new approaches in defending cases, particularly when the statute had never been tested at the trial or appellate court level.) And it is possible that, if a guideline were adhered to and a case filed, that a defense attorney may have chosen to defend the case in a traditional way rather than asserting the affirmative defense and ending up in the State Supreme Court testing this unique approach. Finally, the defense attorneys were concerned that, despite the clear language in the statute, the guidelines would be somehow used against the physicians in instances in which they did not adhere to them.

But, as influential as the defense attorneys may have been in the termination of the project, there were several other factors that contributed to the statute's not being used. Perhaps the most significant was the relative amount of practice affected by the project. While at the time, 19 guidelines in four specialties seemed reasonable, in retrospect, the protocols did not cover enough practice to concern even a few malpractice cases over the 8 years. For instance, the only two guidelines in emergency medicine involved the cervical spine x-rays discussed above and interhospital transfers. Although it is not an observation based upon much evidence, I estimate that all of the protocols put together did not touch more than 1 to 2 percent of medical practice cases in the state. That being so, it is not particularly surprising that no cases emerged.

In summary, for the most part the physicians who elected to participate and MMA itself do not consider the project a failure. Among the positive outcomes were the distribution of the guidelines to all the physicians in the specialties involved, which many of the specialty leaders believe improved quality by encouraging a more uniform approach to the procedures and treatments included in the project, and the education the project provided to observers around the country on the relationship between practice guidelines and liability protection. Given the proliferation of guidelines since the expiration of the project, I believe that a similar approach should be tried in another state and with more specialties. Virtually all observers of our very expensive medical malpractice system believe that physicians who adhere to established guidelines should be protected from claims of medical malpractice. The Maine Liability Demonstration Project did not prove otherwise. It simply did not confirm that this treatment fit the diagnosis.

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POLICY FORUM
Aligning Values with Value
Audiey C. Kao, MD, PhD

The Doctor, by Sir Luke Fildes, was once one of the most recognized of all Victorian paintings, in part because reproductions of it hung in many doctors' offices. To this day, the painting is often used to portray the core values of what it means to be a good doctor [1].

The parents depicted in the painting are powerless to help their sick child. The truth is that there was little the doctor could do to alter the course of this patient's illness either. At most, the doctor could be wholly present, tend to his patient's needs to the best of his abilities, and comfort the family when the time came. This professional commitment to do whatever one can in the patient's best interest remains a central ethic upheld by modern-day physicians.

While much remains constant in the artful practice of medicine, much has changed in the clinical and scientific basis of medical practice since Fildes painted *The Doctor*. With dramatic advances in biomedical knowledge and technology over the past 25 years, there is no shortage of diagnostic tests and therapeutic modalities that physicians can employ to intervene for the benefit of their patients' health and welfare. The increased capabilities of modern medicine to treat and cure has seemed inextricably linked to the escalating financial cost of providing care to patients. Consequently, there is growing pressure on physicians to be more cost conscious and better stewards of health care resources and on policymakers, at national and local levels, to get more value out of every dollar that is spent on medical care.

How does this relatively new obligation of medical stewardship fit with physicians' long-standing ethic of doing whatever is in the patients' best interest regardless of personal discomfort or financial cost? Through focus groups and a nationally representative survey of physicians conducted in 2011, the American Medical Association (AMA) sought to better understand what physicians thought about the idea of medical stewardship, its relevance in the practice of medicine, and what may facilitate and hinder cost-conscious clinical decision making.

In web-based focus groups, most physicians reported having heard or used the term "stewardship" in other arenas, but not as it relates to health care.

> Stewardship is a word I hear at church. [Being] responsible, taking ownership, looking out for the best interest of the majority,

> doing what is right—not necessarily what is popular—careful use of resources [2].

While physicians' response to the term "stewardship" was mostly positive or neutral, there were some skeptical reactions as well.

> My obligations—professional, legal, and ethical—are to my individual patients. While there are not unlimited resources in any community (including the country as a whole), I don't see my care as a zero-sum game—giving care to one patient does not take away care from another [2].

AMA survey data also revealed that physicians are evenly split about whether they take cost into consideration when making treatment decisions on individual patients (AMA, unpublished data, 2011). Preliminary analyses of qualitative and quantitative data collected by the AMA suggest that physician stewardship of health care resources is accepted as a professional obligation by many physicians, but whether stewardship is a core ethical value in medicine remains an open question. A significant number of physicians believe that taking cost into consideration when making clinical decisions would be antithetical to being a "good" doctor.

In light of this evolving values landscape in medicine, a variety of policymakers and stakeholders are moving ahead with initiatives designed, in part, to bend the cost curve and to get more value out of every dollar spent on health care. These initiatives range from proposing new ways for physicians to be reimbursed (such as pay for performance or value-based purchasing) [3] to considering how patient care could be delivered (such as the medical home or accountable care organizations) [4, 5]. In addition to fundamental changes in financial incentives and the work environment in which care is delivered, there are educational efforts designed to help physicians make better cost-conscious decisions. Some have even recently advocated for a new stewardship "competency" to be included as part of the core set of competencies that residency programs should be responsible for imparting to the newest physicians [6].

A lack of professional consensus about the ethical status of physician stewardship may hinder educational programs and policy efforts to lower costs. By engaging in a professionwide conversation about the relevance and appropriateness of stewardship as a core value in medicine, can we hope to reach reasonable consensus on this matter of ethical import? If that does occur, an alignment between professional values and health care value will increase the likelihood that we can build an economically sustainable health care system.

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POLICY FORUM

American Medical Association Policy—The Individual Mandate and Individual Responsibility

Valarie Blake, JD, MA

With federal appellate courts split on the constitutionality of the Patient Protection and Affordable Care Act (ACA) and 26 states and the Obama administration appealing for review, it's more likely than ever that a Supreme Court ruling on the act will take place in the near future [1]. Central to the debate about the act's constitutionality is the individual mandate, which requires all Americans (with some narrow exceptions) to obtain a certain level of health insurance coverage [2]. The financial lynchpin of the ACA, the individual mandate reduces the cost of health care insurance overall by widening the pool of participants who pay into health insurance and reducing the number of "free-riders" who receive care without paying in [3]. The American Medical Association (AMA) has supported the individual mandate since 2006, based on theories of individual responsibility to obtain health insurance and a pressing need to bring health care to the uninsured.

In other contexts, the AMA has sometimes called for the minimization of health care mandates. One policy opposed any health benefit mandates unrelated to patient protection that might jeopardize coverage for those already insured [4]. Another called for a regulatory environment that enabled rather than impeded private market innovation, including the minimization of benefit mandates "to allow markets to determine benefit packages and permit a wide choice of coverage options" [5]. Yet another reaffirmed the AMA's "commitment to private health insurance using pluralistic, free enterprise mechanisms rather than government mandated or controlled programs" [6]. The AMA opposed socialized or nationalized health care in favor of individual choice and free-market strategies in 1998 [7].

Historically, however, AMA policy has supported the ideas underlying the individual mandate of the ACA; "expanding health insurance coverage and choice have been long-standing goals of the AMA" [8]. Earlier policies of the AMA on the topic of health reform acknowledged the need to obtain "universal coverage and access to health care services" [9]. The Council on Medical Services, the AMA group charged with studying this issue since the early 1990s, has examined a variety of alternatives that might broaden access to health care but ultimately, in 2011, reaffirmed its 2006 policy emphasizing requirements that individuals obtain health insurance [8]. The AMA has focused on individual forms of health insurance, rather than employer-based forms, as the organization rebelled against managed care and employer-based care, which sometimes "interfere[d] with patient choices and physician decision-making"[10].

Requirements of individual responsibility were deemed necessary by the AMA to avoid the free-rider problem, in which care for the uninsured is paid for by others, and adverse selection, which occurs when low-risk individuals opt out of insurance, because both circumstances raise costs for everyone else [10]. In its 2006 report "Individual Responsibility to Obtain Health Insurance," the council noted that

> there are some individuals with high incomes whose failure to obtain health insurance poses an avoidable social burden. Such individuals have a responsibility to obtain coverage. Individuals with lower incomes also have the responsibility to seek and maintain coverage, but their burden to do so is tempered by their ability to afford the potentially high cost of coverage [10].

Refundable, advanceable tax credits inversely related to income are the favored method for promoting individual responsibility and lowering cost overall [9]. In 2006, the council ultimately recommended support of a requirement that all families and individuals earning more than 500 percent of the federal poverty level obtain catastrophic and preventive health insurance [11]. For those with incomes below 500 percent of the poverty level, a mandate to obtain catastrophic and preventive health insurance is only required "upon implementation of a system of refundable, advanceable tax credits inversely related to income or other subsidies" [11].

At the most recent annual meeting of the House of Delegates of the AMA, a heated debate led to a vote of 325-165 to reaffirm the above policy supporting individual responsibility to obtain health insurance [12]. This is in line with the ACA's individual mandate, which affords a premium tax credit for families and individuals that is both refundable (so those with little or no income tax liability can still benefit financially) and can also be paid in advance to insurance companies to cover or lessen the cost of premiums [13].

In addition to its approval of individual responsibility to obtain health insurance, the AMA has two current health policies that carve out specific requirements for an individual mandate. First, in the context of an individual mandate, the AMA supports health insurance coverage of preexisting conditions with both guaranteed issue and guaranteed renewability [5]. Thus, it rejects an individual mandate that would require the purchase of health insurance but not ensure that individuals with preexisting conditions could receive it and renew it. This requirement is satisfied by the ACA, which currently provides an alternative health plan for those with preexisting conditions, and, in 2014, will ban insurance companies from refusing coverage to these groups [14, 15]. Another AMA policy encourages the involvement of patients and practicing physicians in determining the "minimum creditable coverage for an individual mandate" [16].

While the AMA has generally favored individual choice over government mandate, its policies have long noted the importance of individual responsibility to obtain health insurance and the significant role this plays in making universal health care

coverage achievable. As the Supreme Court takes on the question of whether states or the federal government should regulate health care and whether the purchase of health insurance can be required, the notion of individual responsibility and the integral role it plays in insuring the uninsured will be a key theme to consider.

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MEDICINE AND SOCIETY

Health Reform and the Future of Medical Practice

Randy Wexler, MD, MPH

The only thing that is certain in medicine is that nothing is certain in medicine. Although health care has changed in many ways over the years, nothing will have a greater impact on how care is delivered than the Patient Protection and Affordable Care Act of 2010 (ACA). Many physicians are angry at passage of the ACA, and lobby for it to be repealed, but there are reasons that this law was passed by Congress. The lack of health coverage for tens of millions of Americans, poor care coordination, absence of patient-centeredness, focus on the quantity of services delivered as opposed to the quality of patient outcomes, and high cost that does not necessarily translate into improved patient health all set the stage for passage of this law. Most physicians are familiar with the aspects of the ACA that increase coverage through creation of health insurance exchanges and expansion of the Medicaid program. Fewer are aware of how changes to reimbursement will revolutionize the way they practice.

Although health care policy may at times appear as though it is being made in a vacuum, that is not the case. To evaluate the incentive-based reimbursement mechanisms that are now being promoted by the ACA, the Centers for Medicare and Medicaid Services (CMS) conducted the Physician Group Practice (PGP) demonstration project starting in 2005 [1]. A diverse group of 10 health systems, with varying structures and physician cultures, participated [2]. When the results were published in the spring of 2009, the 10 groups had reported meeting 29 of the 32 established goals [1]. Half of the health systems together saved Medicare a total of $38.7 million, earning an incentive-based payment of $31.7 million [1]. More than half of this went to the Marshfield Clinic in Wisconsin, a health system comprising 775 physicians in more than 80 medical specialties and subspecialties located in 54 sites throughout Wisconsin [3]. Based in part on the demonstrated success of coordinated care in this pilot project, the ACA made coordinated care a centerpiece of health reform, calling for the establishment of accountable care organizations (ACOs).

Accountable Care Organizations and Episode-Based Payment

An ACO is a health care delivery structure comprising various primary and specialty care physicians, hospitals, ancillary providers, subacute nursing facilities, and others that together are held accountable for the cost and quality of the care they deliver [1]. To succeed, an ACO must: (1) manage patients across all types of care including inpatient, outpatient, and ancillary; (2) prospectively plan budgets and resource needs; and (3) provide valid and reliable performance data [4]. To encourage

providers to adopt the methods necessary to make such changes, the CMS will likely move from fee for service to other forms of reimbursement.

Most physicians are familiar with payment under Medicare's diagnosis-related-group (DRG) mechanism. In this form of *bundled payment*, Medicare reimburses a fixed amount for all care delivered to a patient during an inpatient admission. In the near future we are likely to see a transition to *episode-based payment*—payment for all services, including physician, hospital, and ancillary care, provided to a patient during an *episode of care*. In this model, an episode may extend from the inpatient period to days or weeks after discharge. This lengthening of the time period payments cover, from an admission to an "episode," is likely to eventually extend even further, to global capitation, which entails fixed payments shared among all caregivers for the total care a patient may need in a given time period, based on actuarially determined rates.

When this transition occurs, physicians will need to negotiate for their "piece of the pie." They will have to learn to relinquish some of the autonomy they have historically enjoyed because they must now care for patients in teams in which there is more than one captain. Culture change will be the single biggest barrier for physicians to overcome, regardless of how health care changes.

Changes to the Culture of Medicine

To survive in this new environment, it will be incumbent on physicians to adopt new ways of thinking and strategies that are integrated, comprehensive, and coordinated.

Coordination of care and timely transmission of information. Poor care coordination in our current health system contributes to suboptimal outcomes, not to mention increased cost. Factors that contribute to this problem include poor communication, wrongly completed forms, the lack of relationships between physicians and other health care workers, and the use of informal support mechanisms such as curbside consults [5, 6]. Between 1995 and 2006, communication breakdown was the leading cause of sentinel events reported to the Joint Commission on Accreditation of Hospitals [5], and assessment of the level of communication between hospital physicians (HPs) and primary care physicians (PCPs) reveals significant cause for concern. Bell and colleagues evaluated the frequency of communication between the two groups regarding patients hospitalized for various medical problems [7]. Only 77 percent of PCPs were aware their patients had been hospitalized. HPs and PCPs communicated about the hospitalized patient only 23 percent of the time, and a discharge summary was available within 2 weeks in only 42 percent of admissions.

Poor care coordination is due in part to physicians' practicing in semi-isolation—caring for patients within their offices or chosen institutions, and often focused on a narrow disease set or specific medical problem. In the future, physicians will need to adopt mechanisms for communicating clinical information in a timely fashion, as well as being more comprehensive in their approach to patient care. It will not suffice for physicians to send discharge summaries to other physicians a week later

or tell patients to call other doctors when they are too busy to see them. Such practices impact outcomes negatively, and in the future they will affect reimbursement negatively. Furthermore, physicians will be responsible for a patient's care not only within their office or health system but also when their patients are cared for in other systems. This will require a fundamental change in culture. Physicians will need to establish new, trusting relationships outside their usual comfort zones. They will need to communicate, collaborate, make themselves accessible, and work in shifting teams in ways they never have before.

To support needed change and promote the timely transmission of data both within and between physician offices, health systems, hospitals, and other care providers, a robust health information technology (HIT) infrastructure will become necessary.

Greater focus on preventive care. HIT will also transform how physicians care for patients by making the practice of medicine proactive (prevention-based) rather than reactive (based on disease acuity). Health care today is typically reactive in nature. Patients get treated when they have flareups, acute episodes, or bothersome symptoms—exacerbations of asthma, myocardial infarction, discomfort, and so on. Though such care will still be necessary, a transition to a more proactive practice method will occur in the future. Patients will certainly continue to experience chronic disease, but, given that upcoming reimbursement models will probably emphasize quality of outcomes over quantity of interventions, the focus will be more on preventing that disease or its sequelae in the first place.

HIT will be an important part of those efforts. In most offices today a patient with diabetes, for example, is seen every 3 to 6 months, depending on disease state and comorbidities. It is the responsibility *of the patient* to return for care. In the future it will be the responsibility *of the physician* to ensure the care is delivered. When reimbursement is likely to be increasingly tied to quality of outcome rather than quantity of care, it will be incumbent on physicians to ensure that patients (in this case, those with diabetes) receive recommended care whether they take the initiative to come to the office or not. This will require leveraging HIT to develop solutions, such as disease registries that track desired parameters such as A1C and LDL levels, blood pressure, and monofilament exams. When numbers are outside the desired range or such services are due to occur, automatic reports can be sent to physicians so that patients can be contacted *proactively* and the needed care provided. HIT also provides the means to track other needs and populate orders or send reminders to physicians at the time of an unrelated visit: a patient may be coming in for diabetes monitoring, but does he or she need a pneumonia vaccine, flu vaccine, a colonoscopy, or other preventive service? Such clinical management support would help to bridge the gap between what is currently being done and what needs to be done.

Improved access to care. The *how* of medical care will certainly change in the future, but so will the *when*. Significant numbers of patients currently seek care in emergency departments (EDs), urgent care facilities, or retail clinics because they

cannot see a physician at a time that works for *them*. If physicians are reimbursed by service, they are not penalized when this occurs. When reimbursement is tied to episodes of care, quality markers, and financial targets, the use of the ED for nonurgent care will not be practical. The Center for Studying Health System Change found that only 47.3 percent of patient visits to the ED were classified as either urgent or emergent [8]. The need to improve access to care and reduce cost will require physicians to rethink their work day, the hours during which they are available, and other kinds of access for patients such as e-mail or web portals.

Conclusion: ACOs Are Coming

It is my belief that we are headed towards a health system that reimburses based on global capitation. Such a change allows the government and others to better estimate expenditures and places responsibility (risk) for cost on providers; the primary incentives in the new system will be the reduction of care determined to be unnecessary on a population level and, hence, of overall costs. The institution of ACOs (or whatever the mechanism becomes) is the start of such a direction. Episode-based care *is* the first step toward global capitation, to an even greater degree than physicians have seen before. Should that occur, physicians who have not laid the groundwork for such change will find themselves in a precarious financial position. In a global-capitation world, physicians will need the lessons learned from their ACO experience to succeed.

Many will say that they have heard such predictions before and nothing ever happened. They believe the same will occur will this time. I believe they are wrong. The percent of GDP devoted to health care continues to rise. Baby boomers are starting to retire. We are in the middle of the worst economy since the Great Depression. The can has been kicked down the road for decades, but we have run out of road. Physicians will not be able to ignore the seismic changes in health care that are occurring all around them. The first ACO is scheduled to go live January 1, 2012.

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HISTORY OF MEDICINE

How Medicare and Hospitals Have Shaped American Health Care

Robert Martensen, MD, PhD

For most physicians and surgeons, cultivating good relationships with hospitals only became important in the twentieth century. Late-nineteenth-century advice books on professionalism for physicians seldom mentioned hospitals, for example. Instead, they provided specifics on what seemed of greater moment: proper manners with patients, professional dress, lettering on the office window, and etiquette of professional interactions. From the 1890s onward, however, developments in "scientific" surgery—widespread general anesthesia, aseptic operating techniques, refined handling of tissues, surgical pathology—favored hospitals, as even opulent private homes no longer proved adequate for surgical procedures.

The idea that one needed hospitals to control all phases of life-threatening medical episodes has only arisen since World War II, however. As late as the early 1950s, the way internists cared for patients with heart attacks—opiates and extended bed rest—was closer to Galen's approach than to today's. Most medical diagnostic and therapeutic interventions could be performed in physicians' offices, private labs, and patients' homes.

The convergence of three major factors brought hospitals to the fore for everyone from the late 1950s onward. First, aggressive medical and surgical treatments—such as chemotherapy regimens, extended courses of IV antibiotics, and increasingly invasive surgeries for breast cancer began going mainstream. By the late 1960s intensive-care technologies were becoming common, and patients and physicians wanted more of them. Congress, the executive branch, and state legislatures obliged with expanded federal subsidies for hospital-building programs and tax-exempt bonds.

What cemented the centrality of hospitals was the passage of Medicare and Medicaid (Public Law 89-97) in 1965. By 1966, more than 19 million individuals ages 65 and older were enrolled. Premiums were modest: in 1970, Medicare Part A, which covered hospitalizations, had a deductible of $52 per year, and Part B (supplemental medical insurance) charged a monthly premium of $4. Nonetheless, for hospitals, especially urban ones, Medicare and Medicaid caused a sea change. What had been for centuries their most problematic service group—the elderly indigent—in a trice had become, now that their care was monetized, desirable.

Almost everything Medicare supported was done on a "cost-plus basis," though it wasn't called that. It didn't take long for community hospitals, academic medical

centers, and doctors to realize that "cost-plus" reimbursements and no overall budget caps meant they could realize their big dreams, especially those that required expensive facilities, staff, and trainees, and then dream new ones.

From the perspective of hospital leaders, medical school deans, and physicians, it was perhaps best of all that Medicare made few demands and asked few substantive questions. Throughout the 1970s and for most of the 1980s, as long as the paperwork was legit, the bills got paid. Composition of the medical workforce provides a telling example. Previously, clinical training programs had been the financial obligation of hospitals; now Medicare paid, and the programs expanded considerably. New specialties emerged and older ones spawned subspecialties. Training programs extended in time, and billing codes paid sizeable premiums for specialist care. For several decades, Medicare paid senior physicians for services to patients that had been rendered completely by their trainees, an example of a single Medicare detail that enabled a generation of procedural specialists to make not merely a good living, but to become genuinely wealthy. In most instances, insurance companies followed Medicare's lead.

Meanwhile, although federal legislation (Hill-Burton) may have been winding down its direct subsidies of hospital building programs, legal decisions, tweaks in Medicare hospital payment formulas, and state legislation meant hospitals still had access to abundant capital at comparatively cheap rates. They, like the schools, professional organizations, and many physicians, adopted an approach of atomized hustle and scramble as they sought to maximize their individual situations.

It should be no wonder that the period from 1965 through the mid-1980s, an interval when almost every current senior leader in U.S. health care underwent professional formation, is often remembered by them as the "Golden Age" of U.S. medicine. For them, Medicare and hospitals have been the center of the medical universe. Present-day leaders, whether in the hospitals, insurance companies, Congress, the professional organizations, or the schools, often have difficulty imagining a world in which cost-plus reimbursement and laissez-faire behavior do not coexist in happy symbiosis.

Throughout much of its life, Medicare's approaches to physicians and hospitals have been rife with internal contradictions. Soon after it started, Medicare expanded offerings, a practice that has continued, notably in the very expensive Public Law 108-173—the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Beginning in 1980, though, Medicare also began systematically trying to limit growth in payments to hospitals and physicians, and that trend finds expression in numerous places in the massive health care reform legislation of 2009 and 2010.

Except where Medicare decides to pursue a particular subject, such as the number of days it will pay an acute-care hospital for ventilator use by a patient, for example, laissez-faire continues as the default norm. Thus, although Medicare pays almost all the costs of training specialists, it exerts little influence on the shape of the U.S.

medical workforce. Many health care organizations, medical schools, and the U.S. government talk up the value of primary care, but increasingly it exists in tatters in the United States, where it exists at all. One reason may be that primary care doesn't pay well—not only for physicians, which is what is usually noted—but for hospitals, medical schools, and professional organizations.

Unintended consequences abound from the foregoing. For example, hospitals have endeavored for years to keep up with changes in Medicare reimbursement formulas (and shape them through their lobbying efforts). When the cost and duration of single hospitalizations seemed of prime importance to Medicare, hospitals vigorously promoted the value of case managers and hospitalist physicians. One unintended consequence for chronically ill patients—adults and children—and their community-based generalist physicians is that they gradually lose touch with each other, as the community doctors no longer spend much time in the hospital and hospitalists don't work with them.

Medicare pays well for procedures, but it often pays poorly for spending time with patients, which is often what chronically ill patients need most. The patients, who may reside many miles from specialist medical centers, may live as medical orphans as a consequence. The situation is particularly poignant for families with children with serious chronic diseases.

For the frail elderly, a group that is disproportionately female, the relentless push by hospitals to reduce length of stay has often meant they spend their final months or year undergoing an agonizing shuttle from acute hospital bed to nursing home, only to be returned to the hospital days or weeks later. Specialists tend to their failing organs in hospital, and nurses oversee their custodial care in nursing homes. No one may know the patient's preferences for comfort, function, and longevity, which means no one crafts a comprehensive treatment plan with them. Instead, frail patients with chronically failing organ systems experience aggressive interventions until their bodies can take no more, at which point they're discharged to hospice or a nursing home to die. Medicare pays the bills.

Although it may be tempting to point at acute care hospitals as key shapers of health care, in reality they mostly function as pawns of Medicare. Medicare shapes much of the quotidian of office practice for most physicians and surgeons as well. But Medicare, giant as it is, increasingly resembles nothing so much as a partisan political football, a situation no other advanced country tolerates in health care financing. A biomedical-industrial complex has arisen in the U.S., and its entities unceasingly try to game the system even as they feed off it. It is not surprising that former Medicare execs often serve in senior capacities in organizations that depend on Medicare's largesse. It also seems likely that hospitals will continue using their economies of scale and access to cheap capital to their advantage in relationships with their medical staffs. Those staffs, in turn, may splinter into factions: hospital-based workers in one group, with subgroups for contractors and employees, and another composed of community-based physicians for whom the hospital is

becoming less central to a successful practice. All parties, including residents if present, will likely continue their atomized scramble and hustle.

In the United States more than anywhere else, patients (and their doctors) find themselves betwixt two value systems: one that casts the patient as consumer, which is what hospitals, drug companies, and health insurers like to promote, and one that views the patient (and family) as one-half of a patient-doctor relationship. That relationship in turn depends on the willingness and ability of physicians and nurses to provide their patients (and families) sound judgments in the face of uncertainty. To the degree physicians permit their judgments to be corrupted by other interests, including the self-serving ones of hospitals, "good doctoring" will prove a challenge. And medicine's social contract, the unwritten but powerful basis of physicians' social and cultural privileges, will continue to vitiate. Medicare takes no official position, but its passivity should not be taken for inaction, as its policies and practices shape almost every aspect of hospital and physician relationships.

Robert Martensen, MD, PhD, is the author of *A Life Worth Living: A Doctor's Reflections on Illness in a High-Tech Era* (Farrar, Straus, & Giroux, 2008) and co-editor of *Surgical Palliative Care: A Resident's Guide* (American College of Surgeons, 2009). He is a lecturer at Harvard Medical School in Boston.

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MEDICAL NARRATIVE

Inside the Senate—A Physician Congressional Fellow's Experience with Health Care Reform

Scott M. Palyo, MD

While I was meeting with constituent groups on Capitol Hill last year, one owner of more than thirty fast food restaurants said to me, "Most of my employees are single mothers in college—what do they need health insurance for?" Not until this surprising conversation did I fully appreciate the responsibility I had as a congressional fellow in the United States Senate. We doctors should not only advocate for the needs of our patients and our profession, but also protect what we have achieved so far in health care.

During my time as a resident and fellow in New York, I was a member of the local board of child psychiatrists and attended events in the state and in Washington D.C. to promote a broader understanding of mental illness and the needs of our patients. In doing so, I began to take an interest in federal governance. This past year, I was the Irving Berlin, MD Congressional Fellow through the American Academy of Child and Adolescent Psychiatry (AACAP), working in Senator Debbie Stabenow's (D-MI) office. Senator Stabenow, who is a social worker as well as a member of the Senate finance subcommittee on health care, has been a great advocate for health care reform.

If you're a physician, you do not see how connected medicine is to politics and business until the day that your grant is not renewed and your research and position are in jeopardy, your patient is refused an intervention, or your facility shuts down. For me it was learning about my residency program's termination as a result of its hospital's bankruptcy and closing. Watching Saint Vincent's Hospital shut its doors, I saw how medicine is affected by business as well as state and local politics. Why didn't the hospital's board foresee and prevent this? Why couldn't the state intervene? I was not able to find any convincing answers to these questions while patients, trainees, and attendings scattered to other hospitals and clinics.

My first day on Capitol Hill reminded me of my first day as a medical student on the wards—I had no idea what to expect, but it turned out to be a dynamic and rewarding experience. During my fellowship year, I was involved with such matters as amendments to health IT programs; facilitating more coordination between departments with regard to children; correcting the sustainable growth rate (SGR) with the Protecting Seniors' Access to Doctors Act (S. 3965); promoting federally qualified mental health centers; heart disease education and research, and resolutions on ovarian cancer, health IT, and Parkinson disease. A typical work week brought

meetings with groups who came to the office to advocate for their organizations' priorities, health care committee meetings and briefings, the drafting of many memos on the topic of the day, and the everyday interactions I had with Senator Stabenow's health care staffers. Almost none of them have worked in a health care setting, but they wield significant influence on health care reform. These relationships showed me how important it is for physicians to offer our knowledge and experience to this energetic and dedicated group. By explaining the clinical implications of proposed policy changes, I was able to contribute as staffers formulated their support of portions of legislation.

In turn, the health care staffers taught me to understand the broader view. Too often we become fixated on one specific concern and lose sight of the big picture. This was evident to me throughout the year—people advocated repealing the entire health care reform bill because the legislation was not everything they had envisioned. It's this lack of support of big-picture ideas that could drag health reform backward. With the signing of the Patient Protection and Affordable Care Act (ACA) in March of 2010, we took a step in the right direction, toward addressing the soaring costs of health care and including many Americans who might otherwise have faced obstacles to obtaining or maintaining coverage. The senator's legislative director helped me understand the nature of health reform by saying, "In 2010, we just gave birth…that's it. Now we will need to nurture and teach our baby through the terrible twos and the rest of childhood, and *then* we can look back and feel proud of our accomplishment."

Lessons from Capitol Hill

The fate of the health care reform bill is still uncertain. The Supreme Court's ruling is yet to come and there is still time for advocacy. Throughout my fellowship, there were many groups, in addition to corporation owners, who expressed opposition to the reform. Unfortunately, many fewer groups who have benefited, or will benefit, from this reform have shown their support.

My experience with medical associations during my year on the Hill was that, unfortunately, each organization focused on its special interests, perhaps assuming others would advocate for the general issues. This was most evident last spring, when only one medical association's representatives voiced dissatisfaction with the block grants and overhauls of Medicare and Medicaid proposed in Representative Paul Ryan's plan. When asked about it, other associations' groups said they were not in favor of this plan, but they didn't bring it up and it was not included in the talking points outline in the organization's packet. It is important for AMA members to be both informed *and* vocal about key issues, such as the following.

The sustainable growth rate (SGR). The Balanced Budget Act of 1997 established that the yearly increase in Medicare payments per beneficiary cannot exceed the annual growth of the gross domestic product (GDP). If the rate of the Medicare increase is lower, then payments to clinicians and hospitals can be increased in the coming year; if it's higher, payments must be *decreased*. Congress has stepped in

repeatedly over the years to prevent reimbursement rates from being lowered, which is called the "doc fix." This was last established in the Medicare and Medicaid Extenders Act of 2010, which continues through January 2012. Although providers have not yet had to accept lower fees, in some cases extending legislation has occurred after the reduction date, and the difference has been paid retroactively. There is considerable fear in the months leading up to each of the deadlines that there may not be another "doc fix."

Limiting Medicare and Medicaid. This year's congressional budget resolution would limit federal funds for Medicare and Medicaid. The Path to Prosperity proposal (also known as "The Ryan Budget") would alter Medicare and establish premium payments to seniors of $8,000 per year to subsidize their private health insurance. This voucher would completely alter the way many Americans receive care. The private insurance would probably have copays, caps, and preauthorization requirements—all of which would effectively prevent seniors from receiving care and clinicians from giving it. In 2012, the proposal would block-grant federal funds for Medicaid to states, which would regulate the Medicaid program themselves. It would not be long before we saw "creative" state plans aimed at curbing costs by refusing services to some of our most vulnerable patients.

Accountable care organizations (ACOs). The ACA laid the ground work for the creation of ACOs to improve care by encouraging more communication between providers and subspecialists and reducing duplication of services. Payments to ACOs, through the Medicare Shared Savings Plan, will be dependent on measurable benchmarks and based on improvements in health outcomes. ACOs remain an enigma to many but are currently being evaluated in trials.

Whether you are a supporter of health reform or have your apprehensions about it, I encourage you to stay informed and begin, or continue, to advocate for your patients and yourself. Here are some ideas:

- Ask yourself: how will proposed changes affect my patients and my ability to function as a doctor? You have a voice as a constituent as well as a member of a health care-related organization.
- Join or continue your memberships with professional organizations that have a strong focus on advocacy.
- E-mail or call your local, state, and federal representatives to voice your concerns. Each representative has a web site, and they are easy to contact. In addition, professional organizations will have a script for you (usually 3-5 sentences) to use about the topic, if you prefer. Offices receive hundreds of calls and letters each week but they do tally correspondence and take your opinion into account.
- Organize visits with your representatives in your home state. August recess is a great time to meet with members of Congress, as most of them are in their districts for an extended period of time.
- Plan a trip to Washington D.C. Most organizations have at least one advocacy day each year, generally during the spring, when the weather is

nicer and there is more discussion about the budget. You can attend one of those events or call the representative's office and visit on your own (although there are advantages to being part of a group).
- Many members of Congress set aside at least an hour a week to meet with constituents in an open forum. This usually takes place in the morning before Congress is in session for the day and involves 5 to 10 minutes with the representative, additional time with his or her staffers, and a photo opportunity. This is relatively informal, and families are welcome to attend.
- Encourage your patients to speak up and let their voices be heard, either individually or as members of an organization.

Too often we remain silent on issues that could have major impacts on patients and our livelihoods. I encourage you to change and be as vocal with your support for health care reform as others are with their dissatisfaction.

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OP-ED

The Affordable Care Act—A New Way Forward

Vivian Ho, PhD

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA). The law is a step in the right direction, doing exactly what its name states: making health care more affordable for all Americans. Health care expenditures in the United States reached $2.6 trillion in 2010, comprising 17.6 percent of gross domestic product [1]. Increases in health care expenditures are the driving force behind rising health insurance premiums, such that the average cost of insuring a family of four is now $13,770. As insurance has become increasingly unaffordable, more Americans have been forced to go without it.

The ACA helps to make health care more affordable in two ways: by providing insurance coverage for approximately 50 million people who are currently uninsured and by striving to control health care costs by changing how medical services are paid for. First, the law offers health insurance to some subgroups of the currently uninsured, so that they can obtain care with a copayment or coinsurance rate, rather than paying the full price of a physician visit, hospital stay, or prescription drug. For example, the ACA has already enabled parents to add their dependents up to age 26 to their own plans. In 2014, health insurance companies will no longer be able to deny customers coverage due to preexisting conditions. Also in 2014, families with incomes at 133 to 144 percent of the federal poverty level will be able to purchase a health insurance plan with benefits specified by the federal government at a cost no more than 3 to 4 percent of their income, or slightly under $2,000. Similar subsidies will be available on a sliding scale for families with incomes up to 400 percent of the poverty level. The federal government will provide the funds needed to low-income families to enable them to purchase health insurance at these specified costs.

The public disagrees on the merits of using more taxpayer money to reduce the number of uninsured persons. One of the most compelling arguments provided by economic research is that the expansion of the Medicaid program in the 1980s and 1990s led to an 8.5 percent reduction in infant mortality and a 5 percent reduction in child mortality [2, 3]. A recent Institute of Medicine report estimates that the monetized lifetime value of the improved health that would be gained by covering the uninsured (so that they obtain needed care) exceeds the costs of paying for this additional insurance [4].

The second way that the ACA makes health care more affordable is its concerted effort to control rising health care costs while ensuring high-quality care for those who already have health insurance coverage. These features of the ACA have

received less public attention because most people (and the media) do not fully understand our complex health care system. The majority of both public and private health insurance reimbursement mechanisms reward physicians for providing greater *quantities* of services, rather than providing higher-*quality* services. Health care professionals are richly rewarded for performing more open heart surgeries and angioplasties, while they receive little or no financial compensation for time expended educating patients to practice the healthy habits that would reduce the need for costly, aggressive medical treatments.

There are numerous examples of how the current financial incentives lead to high expenditures with questionable value. Between 1997 and 2005 the real cost of treating patients with spine problems in the United States rose from $4,695 to $6,096 per patient. Yet after the additional $85.9 billion was spent, data from surveys of patients who had received treatment revealed that self-reported mental health, physical functioning, work or school limitations, and social limitations were all worse than they had been prior to treatment [5]. Research indicates that only 44.5 percent of Medicare patients underwent stress tests prior to elective percutaneous coronary intervention (PCI), even though clinical guidelines call for such noninvasive testing to confirm the need for treatment [6]. Medicare pays for more than 800,000 PCIs per year, at a cost of $10,000 to $15,000 per case.

The ACA changes per-treatment reimbursement to a system that rewards high-quality care using several strategies. Medicare will soon begin to reward hospitals and physicians for establishing accountable care organizations. An ACO is a group of providers that works together to coordinate care for the patients they serve under Medicare. The Center for Medicare and Medicaid Services (CMS) will track the quality of the group's care and share savings with the ACO if its patient costs are lower than those in a yet-to-be-determined benchmark. ACOs will encourage coordinated care that is likely to improve patient outcomes and simultaneously reduce costs.

The ACA also calls for Medicare to move toward "bundled" payments for procedures such as open-heart surgery or hip replacement. Medicare currently makes separate payments to different health care professionals for services delivered during a single course of treatment, leaving individual physicians and hospitals little incentive to coordinate care. Under the ACA, CMS would move toward paying a single bundled payment to a team of caregivers for an episode of care, so that they will have an incentive to coordinate care and lower costs resulting from complications and delays, in order to earn greater net compensation.

The ACA also establishes an Independent Payment Advisory Board (IPAB) charged with developing detailed proposals to reduce the per-capita rate of growth in Medicare spending. The IPAB has been referred to as a "MedPAC on steroids." MedPAC, the Medicare Payment Advisory Commission, has been advising Congress for years on strategies for improving the structure of Medicare, but it only plays an advisory role. MedPAC issued a report in June 2010 identifying several highly

promising strategies for controlling health care costs, such as coordinating reimbursement for dually eligible Medicare and Medicaid enrollees and adopting novel quality- and cost-improvement strategies that have been used in the private sector. Expanded authority through the IPAB would enable these strategies to be implemented more quickly and comprehensively, again helping to slow cost growth. All of these efforts will slow the rate of increase in health care spending.

Where Does the ACA Need Mending?

The law needs stronger language to empower CMS to refuse coverage for new technologies that are more expensive and yield no demonstrable benefit to patients. The current language in Title XVIII of the Social Security Act states that "no payment may be made [by the Medicare program] for any expenses incurred for items and services…which…are not reasonable and necessary for the diagnosis or treatment of illness or injury" [7]. This language is too weak, allowing marketers of costly new drugs and devices to obtain Medicare coverage for their products even if existing products are equally effective and cheaper. The recommendation to refuse payment for technologies that are both costly and ineffective seems straightforward, but efforts to include cost effectiveness as a criterion for coverage in the ACA led to panicked (and misinformed) outcry about "health care rationing" from the public.

The ACA failed to address the need for price transparency for patients. Physicians and hospitals are not required to post the prices they charge for office visits or elective procedures, making it extremely time consuming and difficult for patients to compare the potential costs of seeking care from different physicians or hospitals. I work in the city of Houston, where local television news reporters have shown me substantial price variations for diagnostic procedures, delivery of a newborn baby, and elective procedures. Having to post the price of services could encourage providers to be more competitive on price, which would aid in lowering costs. Some commentators are skeptical that price transparency will lower prices, because insured patients only pay coinsurance, which is usually a fraction of total costs [8]. However, even insured patients are likely to be sensitive to price variations when they must pay coinsurance rates that are a percentage of total prices. Moreover, insurers would be able to offer lower copayments for physicians and hospitals that charge lower prices and have demonstrated high quality of patient outcomes.

The third area of the ACA that needs mending is the tax on "Cadillac" health insurance. The ACA imposes an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage beginning in 2018. Insurance policies with premiums at this level truly are "Cadillac" policies. The average costs of individual and family coverage in 2010 were $5,049 and $13,770 respectively, so that the overwhelming majority of workers will avoid paying taxes on health insurance for years to come.

I would prefer instead that the tax be expanded to "Chevrolet" health insurance. Currently, employees pay no income, Social Security, or Medicare payroll taxes on the value of health insurance that they obtain through their employers. This causes a

distorted preference for workers to receive additional compensation in the form of health insurance rather than (taxable) wages, which, in turn, leads them to choose much more expensive health insurance plans than they would otherwise. As a result, workers consume some care that likely has relatively little value. This phenomenon, known as moral hazard, leads health insurance to be more expensive than it would be if workers used only care that is worth its full cost [9]. Expanding the number of health insurance policies subject to taxation will nudge workers to think more carefully about insurance premium levels when they are choosing their policies at renewal time. This added price-consciousness will encourage insurers to introduce less generous insurance products with correspondingly lower premiums, which should lower health care costs in the long run [9].

Conclusion

Over the past year and a half, I have struggled to explain many important aspects of the ACA and the U.S. health care system to newspaper and television reporters. I quickly realized that even these well-informed individuals were facing significant difficulties understanding more than 1,000 pages of legislation and with an industry consisting of so many different health care providers and payors for services, with often contradictory priorities and incentives. It is even more unreasonable to expect the general public to understand what must be done to achieve high-quality, affordable health care. Efforts to mend the ACA must come from within the health care profession—from the physicians who have primary authority for prescribing and delivering treatment, as well as the best ability to identify cost-effective care. The federal government can do only so much to provide subsidies and regulations to increase access to health insurance. The future success of the ACA depends on doctors' willingness to take the lead in identifying high-quality, cost-effective health care.

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OP-ED

ObamaCare—The Way of the Dodo

Michael F. Cannon, MA, JM

If you are reading this, chances are good you have traded the luxury of newspapers for medical texts, 24-hour shifts, and chronicling every nanosecond of your day. So let's recap what's going on in the world.

The U.S. government is borrowing roughly 40 cents of every dollar it spends, creating a budget deficit of $1.3 trillion [1]. Uncle Sam has been at this for some time; he is now $10 trillion in the hole. That equals roughly two-thirds of everything the United States produces in a year [2]. If we extend current federal tax and spending policies into the future, the size of the federal debt becomes cataclysmic. Think "Greece." Few recognize the extent of the danger, because Congress has cleverly cooked the books to make future debt levels appear merely horrifying.

Let's pick one of Congress's accounting frauds at random: the "sustainable growth rate" (SGR) formula.

This little gremlin cuts Medicare payments to physicians every year on January 1. Or it would, except every year these cuts have come due, Congress has postponed them. But so long as hundreds of billions of dollars of *future* cuts remain on the books, future deficits and debt appear that much smaller.

Everyone knows Congress is going to postpone those cuts when docs and seniors start complaining. But by pretending that it won't, Congress makes the federal government's finances look better. (The real genius of the SGR is that the cumulative effect of pushing all postponed cuts into future years both preserves the SGR's debt-concealing power and ensures that physicians will grow increasingly desperate to make campaign contributions with each passing year.)

Returning to current events, the unemployment rate has been stuck above 8 percent since January 2009 [3], despite numerous government stimulus packages. Since World War II, American voters have ousted every president who presided over an election-day unemployment rate above 7.2 percent [4]. It is now 9.1 percent [5]. The current White House occupant recommends another government stimulus package.

Stimulating both the federal debt and the unemployment rate is the Patient Protection and Affordable Care Act of 2010, better known as "ObamaCare," a moniker even its namesake now embraces.

During the initial debate over ObamaCare, House Speaker Nancy Pelosi (D-CA) famously said, "We have to pass [it] so you can find out what's in it" [6]. One irreverent heir to Hippocrates quipped, "That's what I tell my patients when I ask them for a stool sample" [7]. The similarities scarcely end there.

Shortly after the signing ceremony, the *New York Times* noticed that ObamaCare actually bars members of Congress from participating in the Federal Employees Health Benefits Program, throwing them out of their health plans and leaving them with no coverage [8]. Oops. The Obama administration quietly ignored this inconvenient part of the law, thereby holding the political class harmless and allowing President Obama to keep his promise that every American would be able to keep his or her current health plan.

Or at least, every member of Congress. Things ended differently when the law pushed carrier Principal Financial Group (PFG) to exit the market, curing nearly one million ordinary Americans of the preexisting condition known as being able to keep your health plan [9]. Quite unlike how it responded when the law threatened members of Congress, in this case the Obama administration did not suspend, or even bother to discern, the responsible provisions of the law. Evidently, health care "reform" is only for the little people.

The most likely culprit behind PFG's exit was ObamaCare's minimum "medical loss ratio" rule, which requires health insurance carriers to spend at least 80 percent of premium revenue on medical care and quality-improvement activities (as opposed to "administrative costs") or issue rebates to their customers. A study sponsored by the Robert Wood Johnson Foundation and published in the *American Journal of Managed Care* estimates this one requirement will impel so many carriers to leave the market that hundreds of thousands more Americans will lose their current health insurance. That includes 155,000 or so seriously ill Americans, who were protected against premium spikes by their current health plans, but may not be able to afford coverage through any other carrier. Since that study looked only at Americans who buy their own insurance (just 10 percent of the private market) and excluded California (home to America's largest "individual" market), the actual number of seriously ill Americans who lose their coverage may be higher [10].

This 2,000-page congressional emanation also creates two new entitlement programs. The Obama administration confessed that one of them, a new long-term care entitlement known as the "Class Act," is "totally unsustainable" [11]. The Department of Health and Human Services (HHS) shut down the office responsible for implementing the Class Act, reassigned its staff elsewhere, and asked Congress not to fund it. When reports emerged that HHS was scuttling the Class Act, the agency naturally denied the charge [12]. Shortly thereafter, HHS announced it was scuttling the Class Act [13]. ObamaCare supporters were quick to cite the Class Act's spectacular failure as evidence that he law *works* [14]. Naturally, the White House opposes repeal [15].

ObamaCare's other new entitlement program offers considerable subsidies to low-income workers who migrate into ObamaCare's health insurance "exchanges." It creates even larger incentives for employers to lend a hand, whether by dropping their health benefits or by firing these workers and rehiring them as contractors. Those (perverse) incentives, plus the threat of ObamaCare's employer mandate, plus the added labor costs stemming from the law's coverage mandates, have left employers wary of hiring until either the Obama administration reduces the uncertainty by assigning values to these variables, or Congress or the Supreme Court reduces the uncertainty by eliminating them. This entitlement will also prove unsustainable when its cost turns out to be higher than projected, yet still fails to make ObamaCare's mandatory health insurance affordable (see below).

Even if the official spending projections are correct, ObamaCare will add another $1 trillion of new government spending during its first 10 years (actually during the first 6 [16]; another accounting gimmick). One thing it doesn't spend money on: eliminating the SGR cuts. Congressional Democrats promised the American Medical Association *et alia* a permanent SGR fix in return for supporting ObamaCare [17]. That was 2 years ago. Reports that the deal included a bridge in Brooklyn have not been confirmed.

ObamaCare finances half of that $1 trillion of new spending with tax hikes on everything from tanning beds to health insurance to pharmaceuticals. It increases the Medicare payroll tax—in the sense that it applies this tax to non-payroll income, and uses the revenue for things other than Medicare [18, 19]. It finances the other half-trillion dollars of new government spending with promised Medicare cuts that are as bogus as the SGR—but sure do make future deficits look smaller.

When ObamaCare's first batch of mandates took effect in September 2010, carriers notified their customers how much premiums would be raised as a result of these mandates. One Connecticut insurer put the hidden ObamaCare tax in the range of 20-30 percent of premiums [20]. Naturally, HHS Secretary Kathleen Sebelius threatened carriers with bankruptcy if they continued furnishing cost estimates [21]. The notifications stopped.

Earlier this year, the chief Medicare actuary exposed another unknown and (one hopes) unintended feature of the law when he discovered it opens Medicaid to millions of middle-class early retirees [22].

More recently, observers found cracks in the new health insurance exchanges, which under the law may be established either by states or, should they decline, the federal government. With many states balking, *Politico* revealed that the law doesn't actually provide any funding for HHS to create exchanges [23]. And there is exactly zero chance of any such funding emerging from the GOP House.

Legal scholars discovered an even bigger glitch that could scuttle both the entitlement to premium assistance and the employer mandate. It turns out the law

only authorizes premium assistance in *state-run* exchanges. It does not authorize such assistance to those purchasing coverage in a federally created exchange [24, 25].

There is more to this glitch than meets the eye. With the subsidies, six in ten people in Wisconsin's individual market will still see their premiums go up by an average 31 percent, according to MIT economist Jonathan Gruber, one of the law's biggest cheerleaders. (So much for those subsidies making coverage affordable.) But suppose a state refuses to create an exchange and HHS (somehow) creates one. Remember, the IRS has no legal authority to offer premium assistance in a federally run exchange. Gruber estimates that without the law's subsidies, *nine* in ten will see their premiums jump by an average of *41 percent* [26].

In what has become a recurring theme, the IRS says it will ignore what the law says and disburse those unauthorized subsidies anyway [24]. (Given the Obama administration's proclivity for doing whatever it pleases, regardless of what the law says, one wonders why it even waited for Congress to pass a health care law in the first place.) But even this power play may not be enough to save this second entitlement program.

Or the law's "employer mandate." If the Obama administration provides unauthorized premium assistance through federally created exchanges, then some of those subsidies will, under the law's employer mandate, trigger penalties against employers. Employers would then have standing to challenge the unauthorized subsidies in court [25]. In states that decline to create exchanges, those lawsuits could scuttle not only the unauthorized premium assistance but also the employer mandate.

In an ideal world, doctors would be looking over their shoulders at competitors who are innovating to drive down costs. That's how markets make health care affordable today for people who couldn't afford it yesterday. Instead, doctors are looking over their shoulders at federal bureaucrats, who may whack physicians-cum-employers with an employer mandate, and in particular at politicians, to whom doctors must pay tribute lest the politicians cut physicians' pay.

ObamaCare supporters are ignoring the federal government's dire fiscal situation; ignoring the law's impact on premiums, jobs, and access to health insurance; ignoring that a strikingly similar law has sent health care costs higher in Massachusetts [27]; ignoring public opinion, which has been solidly against the law for more than 2 years; ignoring the law's failures (when they're not declaring them successes); and ignoring that the law was so incompetently drafted that it cannot be implemented without shredding the separation of powers, the rule of law, and the U.S. Constitution itself. Rather than confront their own errors of judgment, they self-soothe: *The public just doesn't understand the law. The more they learn about it, the more they'll like it.*

Such behavior can only be explained by the fact that ObamaCare supporters are part of a political movement that has fought for more than a century to secure a government guarantee of access to medical care for everyone. They have suffered a century of disappointments, and have never been so close to achieving their goal—which, to be clear, is not so much *access to care* as it is *the guarantee*. They will cling to this achievement, such as it is, to the bitter end. To modify an old joke: What's the difference between an ObamaCare supporter and a Rottweiler? The Rottweiler eventually lets go.

This denial takes its most sophisticated form in the periodic surveys that purport to show how those silly voters still don't understand the law. (In the mind of the ObamaCare zombie, no one really understands the law until they support it.) A prominent health care journalist had just filed her umpteenth story on such surveys when I asked her, "At what point do you start to question whether ObamaCare supporters are just kidding themselves?"

Her response? "Soon…"

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Suggested Readings and Resources

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