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COMMENT

Implementing economic principles in medicine while maintaining medical professionalism

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Abstract
Introduction Various forms of the managed-care concept have been conceived to reconcile the medical professionalism with necessary cost-cutting measures in health-care provision. A plethora of bureaucratic regulations and required paperwork result in increasing resignation among physicians and withdrawal from patient care.
Options An appropriate option would be to focus not on structures and processes, but primarily on patient-related outcomes. We describe suitable options, their possible consequences, possible developments, and conclusions that can be derived.
Prognoses Neglecting a trustful doctor-patient relationship risks forfeiting fundamental parts of essential health-care provision. Patients' preferences have to be respected, while unnecessary risks and expenses have to be avoided.
Further development At least 12 dimensions influence the balance between medical professionalism and economics. The success of our health-care systems will depend on the best possible mix.
Conclusion An optimal health-care system is characterized neither by the structures nor processes of health-care delivery, but by the quality of patient outcomes. Our patients must be involved in the description of the goals they want to achieve so that physicians can select the best possible ways to attain these goals.

Keywords Managed care · Medical professionalism · Medical economy · Quality · Outcomes

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Introduction

During the past 20 years, the medical profession has been subjected to an economizing process. Since initial steps were taken in this new orientation, opinions have been raised and prognoses ventured. The following discussion is an attempt to reflect these opinions and prognoses and to sketch the possible further development of this process.

If we look up managed care as defined by recognized experts, we find a definition that Porter and Teisberg offered at the origin of the managed-care movement: "The original idea of 'managed care' was simple and elegant–a primary care physician close to the patient would ensure that the care delivered was neither too much nor too little, involved appropriate specialists, and reflected the individual patient's needs and values." (Porter and Teisberg 2006)

This brief description of the actual service provided by the managed-care concept requires the difficult balance between too much and too little patient care. Monetary aspects cannot be found in this original concept. In his original concept, Porter speaks of a service provided by a physician, which we first postulated with a nearly identical content in 1993 (Porzsolt and Gaus 1993; Porzsolt 1993) and referred to as "clinical economics" a year later (Porzsolt 1994).

This term describes the contribution a physician must make in guiding the health-care system because this contribution cannot be made by an economist. But a doctor's contribution can and should not replace that of an economist. Both components—the description of costs by the economist and the description of the values of health-care services by a physician—are necessary to successfully direct a health-care system. Hitherto, we have focused our attention on the role of the economist and have failed—apart from exceptions—when doctors have attempted to mimic economists.

Options

From the viewpoint of economists, the managed-care movement has been gaining in importance in the health-care system because the successes of profit-making management appeared to confirm the correctness of the concept. Economists believe this success can be confirmed in monetary units and is, therefore, evidence based. However, this concept only appears rarely in the scientific literature; a substantial portion of these papers come from Germany (Glaeske 1999; Kirsten 2001; Wasem and Siebert 1999).

This development, appraised as positive by economists, is counteracted by growing resignation among physicians. Physicians' traditional freedom of medical decision-making is being distinctly throttled. Economic arguments are forcing increased regulation of medical care by obligatory guidelines. A growing army of control instances that monitor compliance to standards has increased the number of patients being treated according to guidelines. Whether these improvements in the structures or processes of care have also increased the attainment of the desired goals of health-care provision, i.e., more effectively reducing patient complaints or increasing desired survival, could not hitherto be confirmed. What we most probably can expect from structural or procedural improvements is a reduction in avoidable expenses without limiting the outcome quality. Such measures are, however, difficult to implement for several reasons. The time interval between intervention and outcomes in health-care is much longer than in industrial production. The benefit of most preventive programs can be demonstrated only 10-15 years after beginning a successful program. Second, the compliance of patients as well as the interest of scientists and definitely the interest of politicians will have decreased a decade after initiation of a program. So the time interval between intervention and outcome is an inherent and serious problem in health care. The interests of different stakeholders will also be affected when outcomes instead of structures and processes are assessed as these analyses will likely demonstrate that the costs, but not the medical results are different. In summary, we may in the future address primarily outcomes instead of structures and processes, but at the same time we have to manage the problem of long intervals between intervention and outcome. The solution of these two problems ('the problems of the nothing period') requires a system change, and it will probably be economic reasons that will drive this change.

Prognoses

What economists celebrate as progress is considered demoralizing and demotivating, and as a development in the health-care system accompanied by a loss of physician autonomy by a majority of doctors (Ulmer Papier (2008) of the Bundesärztekammer, Federal Medical Council). This development may appear more dramatic to the doctors than it actually is. Undoubtedly the traditional trusting relationship that has always existed between the family doctor and his/her patient appears to have been sacrificed to the economizing of medicine.

Economized medicine cannot demonstrate this loss of physician professionalism. It is unclear which monetary value should be attributed to a trusting and which to an informative minute of conversation. It is also unclear whether we should orient ourselves to the tariffs of lawyers and tax advisors. Since economized medicine cannot represent this aspect, it is considered to be of little relevance. This attitude, however, violates the scientific principle that missing proof is not the same as no proof or that absence of evidence does not constitute evidence of absence.

These rules suggest that neglecting the trusting relationship between doctor and patient carries a high risk of losing fundamental parts of essential health-care provision. Since intellectuals who are not directly socialized in the provision of health care to patients would not consider the difference between technical and global efficiency (Porzsolt 2008), i.e., the importance of patient preferences for successful health-care provision, considering them inapplicable, a scenario is worth discussing.

Imagine that news reached our health-care system that mammography screening and the therapy recommended for breast cancer by our highly developed health management are distinctly less specific than hitherto assumed. Would patients turn to the responsible managers in this situation? Is a manager the suitable partner to test the reliability of the source of information and the validity of the report? Has s/he experienced the socialization that is required to appear as an authentic contact for the patient? We would like to answer in the affirmative, but only under the condition that the necessary attitudes, abilities, and required knowledge are acquired. In other words, if, ideally, medical education and training have been completed, the manager will be in a position to solve the problems confronting him/her.

This scenario is not unrealistic, but is taking place right now, in 2008. An increasing number of scientists are asking whether the interpretations that have been deducted from available data concerning mammography screening are justified (Gøtzsche et al. 2006; Kaplan and Porzsolt 2008; Zahl et al. 2008). The report roused us and highlighted the necessity of thinking critically about the direction that the development of health-care provision has taken. The critical test of a system always occurs during crises, and the actual performance of a system becomes obvious in such crises. We shall see if those affected by changes in health-care provision turn to us doctors. We should be prepared. We should, however, also consider that the demand for health-care services has already changed, and we physicians have not yet perceived this change.

Donald Irvine, President of the Royal Society of Medicine, summarized the change in the relationship between the medical profession and the public as follows (Irvine 2001): "The relationship between the medical profession and the public is changing, and the professionalism of doctors must evolve accordingly. What has not changed is the fact that the public needs doctors who are knowledgeable and skilled, ethical and committed… As doctors our foremost ethical duty is to serve our patients and the community to the best of our ability. The same duty falls on politicians and managers, even if their ethical codes are a little less well defined. We have to start respecting and understanding each other's values and motives. We may then begin to trust each other."

Patients are beginning to realize that the traditional family doctor, who has taken care of the family for a generation and is aware of all the ups and downs of three generations living under the same roof, will no longer exist in the future.

Further development

We should avoid advocating extreme variants of a professionalized or an economized medicine. The aspects we subsume under these descriptions are listed in Table 1. The goal of well-balanced and appropriate health-care provision should be a harmonious mixture of components from each of the two extreme forms. The new forms of health-care provision, which are discussed in a recent issue of The New England Journal of Medicine in "Beyond Pay for Performance," are moving in this direction (Rosenthal 2008).

It is unrealistic to want to achieve the ideal form of professional medicine without taking economic aspects into consideration. From the viewpoint of physicians, however, it is unacceptable to strive for an economized form of medicine without the essential characteristic of professionalism. It was probably no coincidence that the 100 hospitals considered most successful in the USA a few years ago were all headed by medical and not commercial directors. Ideally, these directors should have the qualifications that are required to achieve the real goals of health-care provision.

Conclusion

It is urgently needed to shape our own way of dealing with the situation by actively introducing guidelines (Porzsolt and Heimpel 2001) that counteract the "autistic undisciplined behavior in medicine" described by Eugen Bleuler (1919). This urgency has existed for 15 years, as Geroge Silberman (1993) from the US General Accounting Office wrote in the doctors' album at an international conference concerning "Goals of Palliative Cancer Therapy" (Porzsolt and Tannock 1993) in 1992: "If you (physicians) will not decide on how to decide, we (economists) will." Since we doctors have not really taken up this topic during the past 15 years, Silberman's statement has become reality. Our avoidance of concrete statements is understandable because we first have to reach agreement among ourselves, and nothing is more difficult than just this unifying process. The pressure in the cooker should now be sufficiently high to venture a new attempt.

Colleagues at the Mayo Clinic (West and Shanafelt 2007) suggest directing attention to two factors in the professionalization of medical doctors—personal factors and surrounding factors. Stress, well-being, individual characteristics, and

Table 1 Extremes of professionalized or economized medicine

	Professionalized medicine	Economized medicine
Organizational form	Non-profit	For profit
Risk	Efficiency	Quality
Financing	Public	Private
Distribution of economic information[a]	Symmetric	Asymmetric
Distribution of prognostic information[b]	Asymmetric	Symmetric
Orientation towards innovation	Reserved	Favorable
Roll of the patient	Partner	Customer
Equality between doctor and patient	Equal	Unequal
Decision making	Problem oriented	Profit oriented
Communication goal	Reach consensus	Convince the other
Motivation of the service provider	Service	Competition
Preferred by	Patients	Healthy population

[a] Under competitive conditions, information cannot be symmetrically distributed between partners because gain is acquired by an asymmetric distribution of information. [b] In health-care provision it is expected that the physician, but not necessarily the manager, has more information than the patient. The principle of hope would, however, be destroyed if every doctor tried to provide a symmetrical distribution of information for every patient in every situation

interpersonal qualities are personal factors. The institutional culture, formal and informal curricula (in this point we have a lot to catch up on in Germany), and the definition of characteristics of the physician's everyday routine are surrounding factors.

Under the title "Time for hard decisions on patient-centered professionalism" Irvine (2004) pointedly describes that patients want doctors who are competent, respected, honest, and who can communicate. Realistically speaking, we are far from fulfilling these expectations. We should consider how determined we are to achieve these goals. If it is really important to us to maintain medical professionalism, we must discuss Irvine's suggestion to make the doctor's license to practice medicine dependent on continuous proof of his/her observation of the principles of medical professionalism. We must also take into consideration that reciprocal appraisal of professionalism is not very easy to put into practice (Arnold 2005). It would probably be easier to accept a catalogue of undesirable signs indicating a lack of professionalism.

The future could lie in a differentiation of health-care provision that initially allows both forms, that of patient well-being and that which has economic gain as a primary goal. If it turns out that the two forms are not considered to be of equal value, the public should decide which of the two is preferable under the aspect of global efficiency (see above).

We must remember that not all aspects of medical professionalism are perceived in the same way in different cultures. Jotkowitz and Glick (2005) impressively demonstrated that the Jewish opinion of medical professionalism coincides with that of Western medicine in the primacy of patient well-being and altruism (love your neighbor as yourself), but has a different standpoint concerning patient autonomy. The Jewish viewpoint affirms forced nourishment of individuals on hunger strikes, which we consider controversial. The Jewish viewpoint also considers the provision of just access to the health-care system as a social duty rather than the duty of physicians.

A sound social consensus cannot be reached if we are not able with the presently available information to document a simple but systematic assessment of the success of health-care services from the viewpoint of both patients and doctors. The effort required is not too great, and the necessary technology is available. What is missing is dissemination of the concept, discussion, and explicit willingness to carry it out.

To implement sustainable new concepts in our educational institutions (Braddock 2004), it will no longer suffice to reward students' performance with good grades (Shrank 2004). In a first step we should concretely distinguish the abilities that characterize medical professionalism. This will only succeed if the educational institutions themselves manage to create a climate on their own premises that, aside from the sober, scientifically oriented concept of evidence-based medicine, encourage an informal system in which empathy is expressed and the patients can be given hope (Suchman 2004). Other authors call this "higher professionalism" in contrast to basic professionalism (Bryan 2003).

Finally, in whichever way possible, the achievement of the actual goal—achieving maximal success in health-care provision with minimal expense—must be tested. It is just this demand that characterizes clinical economics, or "Clinecs." Clinecs is, however, only realizable if the criteria of medical professionalism are fulfilled and abilities are attained to enable us to estimate the value of health-care services, including the psychological importance (e.g. placebo effect) of a preventive, diagnostic, or therapeutic measure, to avoid the risk of bankruptcy of one's own practice, and to apply economic criteria to considerations of health-care provision.

We are striving to give interested colleagues a guideline with which they can easily find the necessary information for this qualification. The decision to acquire this knowledge and to apply it must be reached by each individual for him/herself.

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References

Arnold L, Shue CK, Kritt B, Ginsburg S, Stern DT (2005) Medical students' views on peer assessment of professionalism. J Gen Intern Med 20:819–824

Bleuler E (1919) Das autistisch-undisziplinäre Denken in der Medizin und seine Überwindung. Springer, Heidelberg

Braddock CHIII, Eckstrom E, Haidet P (2004) The "new revolution" in medical education: Fostering professionalism and patient-centered communication in the contemporary environment. J Gen Intern Med. 19:610–611

Bryan CS (2003) Theodore E. Woodward Award. HIV/AIDS, ethics, and medical professionalism: where went the debate? Trans Am Clin Climatol Assoc 114:353–367

Glaeske G (1999) Evidence-based medicine from the point of view of health insurance companies–a frame for qualified freedom of therapy and an improved economy? Z Arztl Fortbild Qualitatssich. 93:421–426

Gøtzsche PC, Nielsen M (2006) Screening for breast cancer with mammography. Cochrane Database Syst Rev CD001877. Review

Irvine D (2001) The changing relationship between the public and the medical profession. J R Soc Med 94:162–169

Irvine DH (2004) Time for hard decisions on patient-centred professionalism. Med J Aust 181:271–274

Jotkowitz A, Glick S (2005) The physician charter on medical professionalism: a Jewish ethical perspective. J Med Ethics 31:404–405

Kaplan RM, Porzsolt F (2008) The natural history of breast cancer. Arch Intern Med 168:2302–2303

Kirsten WD (2001) Evidence-based medicine in clinical practice, more economics in patient care? Presented at the 21st Forum Niedersachsen, September 25th, 1999. Internist (Berl) 42:57–60

Porter M, Teisberg E (2006) Redefining Health Care–Creating Value-Based Competitionon Results. Harvard Business School Press, Boston, p 76

Porzsolt F (1993) Nutzen von Früherkennungsmaßnahmen, was ist gesichert? ATO 12:45–47

Porzsolt F (1994) Klinische Ökonomik—Eine Forderung der Gesellschaft an die Ärzte. Münch med Wschr 136:221–225

Porzsolt F (2008) Wertschöpfung statt Kostenreduktion–Ein Plädoyer für Globale Ökonomische Effizienz. Gesundh ökon Qual manag 1:32–37

Porzsolt F, Gaus W (1993) Wirksamkeit und Nutzen medizinischer Maßnahmen: Ein Beitrag zur Optimierung des Gesundheitssystems. Der Klinikarzt 12:522–528

Porzsolt F, Heimpel H (2001) Professionalisierung der ärztlichen Tätigkeit: Der Beitrag von Leitlinien. In: Arnold M, Klauber J, Sellschmidt H (eds) Krankenhaus-Report 2001. Schattauer Verlag, Stuttgart, New York, pp 109–121

Porzsolt F, Tannock I (1993) Goals of palliative cancer therapy. J Clin Oncol 11:378–381

Rosenthal MB (2008) Beyond pay for performance—Emerging models of provider payment reform. N Engl J Med 359:1197–1200

Shrank WH, Reed VA, Jernstedt GC (2004) Fostering professionalism in medical education: a call for improved assessment and meaningful incentives. J Gen Intern Med 19:887–892

Silbernman G (1993) Cancer palliation: economic and societal implications. In: Porzsolt F: Goals of Palliative Cancer Therapy. International Workshop 23-26 March 1992 at Reisensburg Castle Germany. Cancer Treatment Reviews 19(Suppl A):97-102

Suchman AL, Williamson PR, Litzelman DK, Frankel RM, Mossbarger DL, Inui TS, Relationship-Centered Care Initiative Discovery Team (2004) Toward an informal curriculum that teaches professionalism. Transforming the social environment of a medical school. J Gen Intern Med 19:501–504

Ulmer Papier—Gesundheitspolitische Leitsätze der Ärzteschaft. Beschluss des 111. Deutschen Ärztetages 2008. http://www.bundesaerztekammer.de/downlads/UlmerPapierDAET111.pdf

Wasem J, Siebert U (1999) [Parameter of evidence-based medicine in health care economics]. Z Arztl Fortbild Qualitatssich 93:427-436

West CP, Shanafelt TD (2007) The influence of personal and environmental factors on professionalism in medical education. BMC Med Educ 7:29

Zahl P-H, Mahlen J, Welch HG (2008) The natural course of invasive breast cancer detected by mammography. Arch lntern Med 168:2311–2316