

IDEAS

FOR AN OPEN SOCIETY



PHYSICIANS AND THE BODY POLITIC

American physicians might prove capable of moving the levers of change, were they ready to engage themselves and the public.”

David J. Rothman, Ph.D.
and Tom O'Toole, M.D.

Volume 2 Number 1
JANUARY 2002

OPEN SOCIETY INSTITUTE



PHYSICIANS AND THE BODY POLITIC

Redefining the dimensions of care

A

merican medicine's track record in political engagement is filled with extraordinary contradictions. Many of its professional organizations, particularly its specialty societies, support an army of lobbyists in Washington to make their views known. Yet, individual physicians are remarkably apolitical, disengaged from public life, rarely holding local office or serving on school boards, let alone sitting in a legislature or in Congress. Some professional organizations, most notably the American Medical Association, have steadfastly opposed efforts to bring greater equity to the delivery of health care; instead, in self-serving fashion, they have devoted their energies to enhancing the earning power of their members. But other groups, typically drawn from pediatrics, family medicine, internal medicine, and psychiatry, have spearheaded efforts to bring medical care to disadvantaged populations. Moreover, sometimes physicians seem irrelevant to the political process, as in the design of the Clinton health care plan. They are ignored by advocacy groups and consumer groups on the assumption that trying to recruit them is hopeless. Yet in other instances, physicians are essential to politics, as witness the cooperation of reproductive rights groups with obstetricians and gynecologists in the support and delivery of family planning and abortion services.

BY DAVID J. ROTHMAN, PH.D.
AND TOM O'TOOLE, M.D.

To be sure, such contradictions are found among other professions. But what makes medicine's position substantially different is the absence of a consensus around fundamental principles. The normative questions about engagement and advocacy are unresolved. Medical schools pay no attention to the subject. In a profession that is devoted to oaths and ethical declarations, it is remarkable that general statements of

ethical principles slight civic engagement. Yes, doctors are supposed to be "advocates" for their patients. But whether that means getting one patient the diagnostic test or treatment that she needs, or whether that means helping to get the class of patients the tests and treatment that they all need, is rarely confronted. Young physicians who seek mentoring to pursue a public role usually come away disappointed.

Those who take the path anyway may find themselves passed over for promotion and experiencing the subtle and not so subtle indignities of being the outsider.

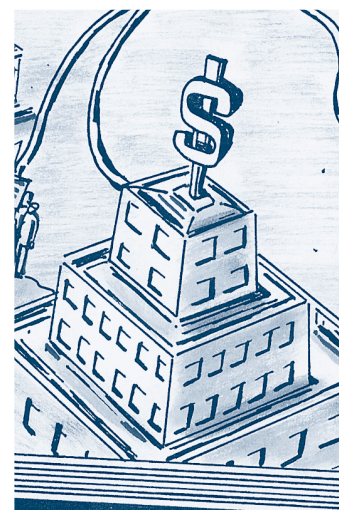
These tensions notwithstanding, there is a fundamental truth that must be better appreciated and promoted both within medicine and the larger community. A civil society grappling with issues of equity and humaneness, in which health care is one of the most central concerns, desperately needs physician input and physician participation. And physicians who truly want to serve their patients must move from a narrow focus on individuals to a more expansive vision of the population. They must confront not only all the special reasons why one patient lacks the necessary resources to maintain good health or access medical services, but the underlying social, economic, and political conditions that contribute to this deprivation among the disadvantaged elderly, persons of color, the working poor, and new immigrants.

Why does the polity need doctors? What would they uniquely bring to the political arena? First, physicians, by virtue of their incomes and their status, are particularly well situated to serve as a political force. Because doctors continue to be trusted and very highly regarded, much more so than lawyers and legislators, their

involvement might help to alter the status quo. At this moment, the political prospects for bringing greater equity to health care are dim. That was already true before the tragic events of September 11, and is even more apparent today. Over the last several months, discussions of such measures as Medicare drug benefits have moved off the political screen, and so has patients' rights legislation. The current administration, already bent prior to September 11 on cutting back social welfare programs, is now even more intent on diverting federal funds away from domestic safety nets. Where someone is brave enough (or foolhardy enough) to mention national health insurance, Harry, Louise, and Hillary would come to mind, not the plight of ordinary citizens who cannot obtain primary care.

These considerations notwithstanding, American physicians might prove capable of moving the levers of change, were they ready to engage themselves and the public. A small cadre is already active and colleagues from the mainstream might join them. There is both a push and a pull. The push comes from a fundamental dissatisfaction with medicine under managed care, and the pull, from a vision of what equitable delivery might mean to their own patients.

A civil society grappling with issues of equity and humaneness, in which health care is one of the most central concerns, desperately needs physician input and physician participation.



IDEAS for an Open Society

In terms of the push, although medicine has always been a way of making a living—and for some specialists, a very handsome living—the driving force that brings young men and women into medicine is not an eagerness to define patients as reimbursable productivity units and enhance stockholder returns in managed care organizations. They go through the rigors of medical school and the still worse hardship of residency programs to learn how to take care of patients; they are neither primed nor eager to evaluate the fiscal implications of proposed health system mergers, for-profit conversions, or capitated reimbursements for covered lives. Yet this is the very envi-

Physicians, by virtue of their incomes and their status, are particularly well situated to serve as a political force.

ronment that they enter, carrying with them an educational debt that averages over \$100,000.

Since physicians serve as the buffer between patients and their employers or insurers who are scrutinizing the bottom line, a profound tension is almost inevitable. The company may not want expensive and still unproven therapies discussed—this was the case, for example, with bone marrow transplants for advanced breast cancer—or it may want the physician to use the less expensive, even if less effective, nausea medication for chemotherapy. Physicians find themselves in a tight bind: either do not provide optimal care to patients or disregard the rules and regulations of insurers and employers and run the risk of being dismissed or losing substantial income.

In responding to this tension, some physicians accept corporate-driven health care and restrictions on their own medical decision-making. Becoming cogs in a health care machine, they allow their practice to be measured in reim-

bursement rates, relative value scales, and billable services. Others will periodically game the system for a particular patient. Their reports will omit facts that might disqualify a patient from care (for example, a drinking history that accompanies clinical depression), or “upcode” a medical visit (inventing symptoms so as to justify a diagnostic procedure or preferred pharmaceutical drug), or lean on a specialist friend to see the patient without charge. In either case, by trying to keep medical expenses well within company specifications, physicians pay a personal toll under the current system. They tell interviewers that they would not want their children to go into medicine. Or they retire early. Or they whine about managed care, albeit only in hospital hallways.

Still other physicians—a distinct minority—find a niche at a community health center, a free clinic, an inner city hospital or any one of the safety net settings providing care to those patients lacking insurance and resources. But it is typically care on a shoe-string, often at lower quality and in a less timely manner, and the setting itself often isolates (and marginalizes) the providers from the rest of the profession. These physicians may be able to accomplish some good on a retail level, but they exert little impact on wholesale practices.

The ultimate problem is that none of these choices insulates physicians or patients from the vagaries of a health system, which awards contracts to the lowest bidder and provides no assurance of health care to some 40 million Americans. Physicians working within a tightly structured managed care setting continually face the pressure to increase productivity and reduce costs. At the same time, as a survey of Baltimore physicians who work with uninsured and disenfranchised patients revealed, even those at “safety net” sites express a deep frustration with their practices and a sense of compromised professionalism. Not being able to get patients the care they need because they are homeless, poor, addicted, or without insurance takes a heavy toll. As one physician put it: “It saddens me. I feel at times that the care we give borders on ‘malpractice’ because many of these clients cannot receive the specialty care they deserve. It is equivalent

to working in third world countries in that sense.”

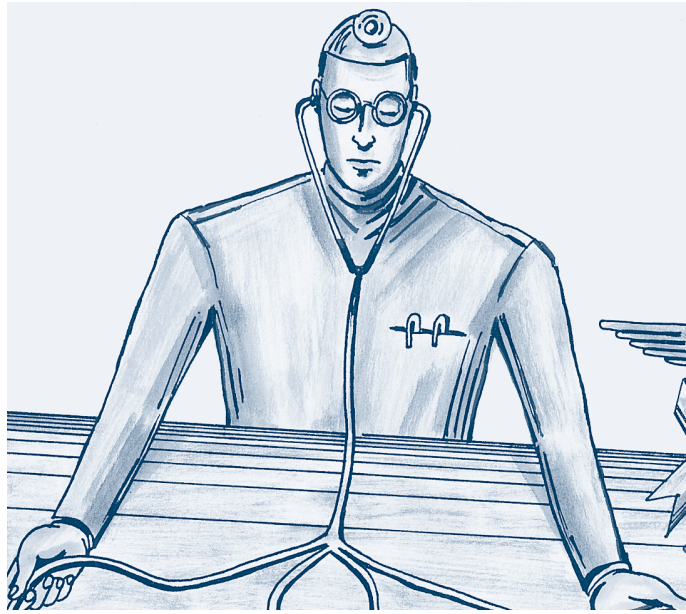
What is to be done? The capacity of the medical profession to resolve these dilemmas depends on at least two considerations: a responsiveness to professional values and a new commitment to advocacy. Let us spell out precisely what that would mean.

Physicians know well how to take care of patients. What is required of them is a broadened definition of what that care entails. It has to include not only gaming the system for one patient but advocating this patient’s general interests, and this class of patients’ general interests. Physicians need the skills and the commitment to translate their own feelings of frustration into an agenda of greater accountability from the profession itself, insurers, and society-at-large. Physicians must challenge a system of care that is structured on behalf of shareholders and speak out on setting new national health care priorities. If the medical profession is to fulfill the covenant that exists between the doctor and patient, a new order of professionalism marked by advocacy and collective action has to emerge.

To this end:

- Medical schools and residency programs should reform the education and clinical training of physicians to incorporate advocacy and skill development and provide both a broader and more directed sense of professionalism and societal responsibility in the curriculum.

- Physicians must transform their professional societies into organizations that advocate on behalf of patients. Medical societies should not be in the pockets of corporate interests or driven exclusively by members’ financial interests. Infusing idealism and leadership within professional organizations can bring like-minded physi-



cians together and give them a stronger collective voice. Models do exist, as in the case of the American Academy of Pediatrics and the Society of General Internal Medicine.

- Physicians must speak out on behalf of new health care initiatives, to put a face to the story of health care inequity. Let them tell the media and the legislature what it means to feel a mass in a patient’s belly, recommend an immediate scan, and be told by the patient that there is no way he can afford it. Or what it means to diagnose a dangerous infection, prescribe the most effective but expensive antibiotic, and be told by the patient that there is no way she can afford it.

Or what it means to diagnose a dangerous infection, prescribe the most effective but expensive antibiotic, and be told by the patient that there is no way she can afford it.

- Consumer and general advocacy organizations should break their own insularity and seek physician participation. Doctors can be powerful allies and they should be invited into the ranks of change-minded groups.

In the normal course of things, expectations for accomplishing such an agenda would be low. But these are unusual times, which may bode well for new and necessary departures.

David J. Rothman, Ph.D., is chairman of the board of advisors of the Medicine as a Profession program at the Open Society Institute. He is also the Bernard Schoenberg Professor of Social Medicine and Director of the Center for the Study of Society and Medicine at the Columbia College of Physicians and Surgeons. Dr. Rothman has written extensively about the history of medicine, as well as current health policy and practice, ethics of human experimentation, and medical professionalism.

Tom O’Toole, M.D., is a program officer for the Medicine as a Profession program at the Open Society Institute-Baltimore. He is a general internist on the faculty at the Johns Hopkins University School of Medicine where he is the associate director of the Urban Health Institute and conducts health services research related to access to care for vulnerable populations.

Dr. Michael Fine and the Future of Health Care

Defining the physician's responsibility for public health

In 1976, Michael Fine was cobbling together a living working part-time for a New York cardiologist while taking science courses at night school. He ghostwrote published articles for the cardiologist who began inviting Fine to accompany him on his rounds, introducing his young companion as Dr. Michael Fine fresh out of Harvard. One day, feeling under the weather, the cardiologist asked Fine to cover for him at the hospital. Fine refused and ended their association.

For Fine, who today is a real M.D. practicing family medicine in Scituate, Rhode Island, this experience was an epiphany. “It got me thinking how vulnerable people are in terms of medicine,” Fine recalls. “There’s no internal protection.” A potentially dangerous relationship exists, he

BY ANDY MIARA

says, between physicians who possess abstruse scientific information and

patients who must trust that their medical well-being is foremost on their doctor’s agenda. Much of Fine’s career has been dedicated to protecting the integrity of this fragile relationship.

The cardiologist’s behavior was unusual. More frequently, the real problems are systemic. Physicians must choose between serving their own financial interests (as well as those of their employers) or serving the needs of their patients. Dr. Fine, who carries himself with the comfortable charm of a favorite high school teacher, has developed a social theory of medicine that describes this tension. In Fine’s view, the medical profession is both a commodity, “containing proprietary information protected by the laws of the state which govern commerce, and a covenant between a physician and the public.”

THE KERN CASE

In 1996, this systemic tension was made public through a series of events that have become known as the Kern Case. David Kern, M.D., a nationally renowned occupational medicine specialist, worked in the Department of Medicine at Memorial Hospital in Pawtucket, RI. While researching a paper he was writing for the American Thoracic Society, he discovered a serious new lung condition affecting people who worked for a particular Pawtucket manufacturer. When Dr. Kern went public, his employers — Memorial Hospital and Brown’s School of Medicine — accused Kern of violating confidentiality agreements he had signed that prohibited the publication of his findings. Kern was fired, despite his protestations that it was his ethical and professional responsibility to publish the results. Then, Memorial Hospital closed its Occupational Health Clinic.

Fine organized a coalition, which included labor unions, the Rhode Island chapter of the American Lung Association, and other concerned members of the medical community, to advocate on behalf of Dr. Kern. Though they were ultimately unsuccessful in having Dr. Kern reinstated, the effort resulted in the creation of the Occupational and Environmental Health Center of Rhode Island, which, thanks to a four-year grant from the Rhode Island Department of Labor and a Soros Advocacy Fellowship, opened its doors in November 2000, as an occupational health center that serves all Rhode Island workers.

To Fine, the Kern Case raised important questions about the physician’s responsibility to public health. “The character of the responsibility of physicians as a class for the public health is not defined at all, and intersects with responsibilities of other bodies and institutions (the state,

hospitals... other professions and professional organizations).”

Yet it is exactly the recognition of this responsibility — physicians as a group working together with other community-based organizations to uphold the public health — which Fine considers a necessary step towards the future of medicine.

SCITUATE, RHODE ISLAND AND THE FUTURE OF HEALTH CARE

In January 2000, for the second year of his Soros Advocacy Fellowship, Dr. Fine organized a community redevelopment project using access to health care as its centerpiece in the small, blue-collar town of Scituate, RI.

With input from Dr. Fine, the town council created the Scituate Health Plan Committee to develop a population-based primary care practice. Funded, among other means, through existing health insurance coverage, the practice provides preventive-care services to all Scituate residents whether or not they have their own insurance plans.

“The work of the Scituate Health Plan represents a huge undertaking,” explains Dr. Fine, noting that no such system of health care currently exists in the U.S. “It proposes to turn the financing and organization of health care services on its head, and build a health care system from the ground up.”

Unlike traditional primary care practices that treat only the patients who come to them, the Scituate population-based practice aggressively seeks out residents to administer preventive-care programs. “Population-based

primary care practices will take it upon themselves to contact the percentage of the population that doesn’t come through their doors,” explains Dr. Fine. “From a public health perspective, it’s a hugely potent way of improving health by attacking the incidence and prevalence of disease.”

Fine is part of a growing movement within the medical community that recognizes the importance of population-based intervention strategies. However, Fine believes, “in order to make that happen, physicians need the community organizing skills to approach the population base.”

The challenge is to make community organizing, often driven by instinct and experimentation, become legitimate in the medical community, which is taught to act on conclusions rather than hypotheses. It is a challenge Dr. Fine willingly accepts. “It’s my job to create enough of an intellectual superstructure around community organizing literature to give it a kind of legitimacy.”

While he labors to construct this superstructure, Dr. Fine is quick to point to the fundamental premise upon which his work is based — a premise that began developing the moment he first considered the physician’s responsibility to the patient. “I think community organizing is more than the future of physician advocacy,” he says emphatically. “I think that physician advocacy viewed in this light may be the future of medicine.”

Andy Miara works in the Communications Department of the Open Society Institute’s U.S. Programs.

The challenge is to make community organizing, often driven by instinct and experimentation, become legitimate in the medical community, which is taught to act on conclusions rather than hypotheses.

Open Society Institute

OSI BOARD OF TRUSTEES

George Soros
Chairman

Aryeh Neier
President

Morton I. Abramowitz
Leon Botstein
Geoffrey Canada
Joan B. Dunlop
Lani Guinier
Bill D. Moyers
David J. Rothman
Thomas M. Scanlon, Jr.
John G. Simon
Herbert Sturz

U.S. PROGRAMS STAFF

Gara LaMarche
Director

Amy Yenkin
Associate Director

Antonio Maciel
Director of Grant & Program Development

Jo-Ann Mort
Director of Communications

PROGRAM DIRECTORS

Ellen Chesler
Program on Reproductive Health and Rights

Tanya E. Coke
*The Gideon Project
Criminal Justice Initiative*

Kathleen Foley, M.D.
Project on Death in America

Helena Huang
*Community Advocacy Project
Criminal Justice Initiative*

Erlin Ibreck
Youth Initiatives

Diana Morris
OSI-Baltimore

Catherine Samuels
Program on Law and Society

Jocelyn Sargent
Southern Initiative

Mark Schmitt
Governance & Public Policy

Susan Tucker
*The After-Prison Initiative
Criminal Justice Initiative*

400 West 59th Street
New York, NY 10019
Phone: (212) 548-0600
Fax: (212) 548-4622
www.soros.org

IDEAS

FOR AN OPEN SOCIETY



OSI and the Medical Profession

The Open Society Institute's program on Medicine as a Profession seeks to invigorate the principles of professionalism in American medicine and apply them so as to advance trust, quality, and integrity in American health care. To these ends,

over the past two years, MAP has designed and implemented a number of initiatives. It funds physician-consumer alliances that aim to reduce the influence of marketplace values in medicine and better secure access to services. It administers a fellowship program for physicians to

promote greater physician engagement in civil society. It has also organized a nationwide service and advocacy program for medical students. Finally, in partnership with United Hospital Fund, MAP is conducting a series of forums that bring together leaders of the medical profession to analyze the current and future challenges to professionalism.

The Open Society Institute is a private operating and grantmaking foundation that promotes the development of open society around the world. OSI's U.S. Programs seek to strengthen democracy in the United States by addressing barriers to opportunity and justice, broadening public discussion

Mission Statement

about such barriers, and assisting marginalized groups to participate equally in civil society and to make their voices heard. U.S. Programs challenge over-reliance on the market by advocating appropriate government responsibility for human needs and promoting public interest and service values in law, medicine, and the media. OSI's U.S. Programs support initiatives in a range of areas, including access to justice for low and moderate income people; independence of the judiciary; ending the death penalty; reducing gun violence and over-reliance on incarceration; drug policy reform; inner-city education and youth programs; fair treatment of immigrants; reproductive health and choice; campaign finance reform; and improved care of the dying. OSI is part of the network of foundations, created and funded by George Soros, active in more than 50 countries around the world.

For an ELECTRONIC VERSION EMAIL:
infoUSprograms@sorosny.org
or VISIT: www.soros.org

Open Society Institute
400 West 59th Street
New York, NY 10019



Presorted
First-Class Mail
U.S. Postage
PAID
New York, NY
Permit No. 8647