Slaves to Medicine
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In a provocative new book, George Beauchamp, MD, claims that physicians are “slaves to medicine.” He explains that this is partly because “when most people go to see a doctor, both the services the doctor provides and the fees that insurance companies allow him to charge are largely predetermined by parties other than the patients and doctors.”

Most patients, in turn, feel completely powerless when the time comes to submit a claim to an insurance company. They are stuck with fees that have been negotiated by a higher authority, and they are not given an opportunity to have a voice in the matter. They are slaves to a master just as people were in 350 B.C.E. (Before the Common Era), when Plato first described “free men” and “slave doctors.”

I grant you that the author’s thesis hit me hard, and I thought it would interest our readers.

Dr. Beauchamp claims that the central truth about health care (one that we often overlook) is a relationship based on trust. Without this special trust, the nature of the profession and its valued outcomes are inevitably perverted. He states that trust erodes when market forces, political control, and third-party interests collide. To regain the trust we have lost, physicians, nurses, pharmacists, and others must once again be placed in positions of authority, creating a morality or, in the author’s words, “a quality of care based on competence.” Finally, this trust can be sustained only when caring professionals subordinate their interests to those of patients. This is heady stuff.

The heart of this new book is the idea that values—not power—should be the drivers of health care. Although many of the messages in Slaves are compelling, I think the author runs the risk of losing his audience when he likens health care of the future to a “family business model” that sees all citizens as part of the health care family, where

some provide services, others require them, and each is responsible for maximizing their contributions. The family is constructed of individuals and is not some shadowy structure created to respond to goals tangentially related to health. The view is long-term, and the benefits accrue to each and all.

I think this concept is dangerously simple-minded and, based on my own practice experience, unworkable. The author envisions a world where we would go to the doctor and take our medications and no charges would exist. The productive outcomes would somehow magically fuel the resource needs of the system.

In the concluding section of the book, the author suggests that there are only two jobs for people employed in health care: taking care of patients and taking care of those who care for patients; any other role in the system is of no added value. I consider this a very narrow interpretation of what our industry is about—and a sophomoric view of health policy, pharmacoeconomics, pharmacoepidemiology, and all of the applied social sciences that help us understand the health care system.

Can I reconcile the notion that values, and not power, should be the drivers of health care? Can I agree that only two outcomes really matter—quality of life and longevity—with the silliness of a federal reserve-like structure, magically ensuring that all patients will take their meds and that we don’t really need a fee structure?

In the end, I cannot support these arguments, but I can appreciate the courage it has taken to disseminate these ideas in a cogent way so that they can be widely discussed.

I also acknowledge that a little book like Slaves to Medicine can help balance some of the political rhetoric that bombards us daily as the presidential candidates crisscross the nation and as snippets about health policy appear regularly in the mass media. Sometimes it takes courage to stake out a position far from the mainstream to help direct the flow of the conversation in an effective manner—thereby enabling us to conduct a meaningful dialogue instead of hearing only disconnected tidbits and sound bytes relating to health policy on the nightly news from reporters who don’t have enough time to discuss the important issues.

So we can forget about health care as

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a long-term family business, and we can disregard the notion that we will never have a transaction-based model. However, we can heartily embrace the idea of value—not power—driving health care and that the two key outcomes of quality of life and longevity should indeed be high on our priority list for the future.

If Professor Nordhaus is right—that 50% of our productivity is the result of improvements in health and in health care—then by all means let’s invest more in the health care system, not less. Let’s embrace the idea of the value of the doctor–patient relationship, and let’s give providers contracts in which they will be paid more for better outcomes instead of being paid for encounters or procedures.

I recommend that all P&T committee members read Dr. Beauchamp’s short book. It is definitely worth devoting some time to a discussion of its main points. We would all be serving our patients better by airing the topics that the courageous author has brought to the fore.

As always, I am interested in your views. You can reach me at my e-mail address, david.nash@jefferson.edu, and you can also visit my new blog at http://departmentofhealthpolicy.blogspot.com.

REFERENCE


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