Presidential Address

Family Not Faustian Values

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IT IS A SPECIAL PRIVILEGE to have been elected President of the Midwest Surgical Association. One that fills me with both pride and humility. The luster of having my professional activities recognized by my peers is quickly counterbalanced by the knowledge that there are so many members of this organization who are better qualified and more deserving for this position. I say this not to question the judgement of those who selected me, but to sincerely thank the entire Association for this honor. I know that I have gotten back more than I have given to this group. The fellowship that I have enjoyed and the friendships that have been made and strengthened by participating in the Midwest Surgical Association are a lasting treasure.

I attended my first meeting of the Midwest Surgical Association 20 years ago when I presented some laboratory research on adrenal autotransplantation that I had performed during my just completed residency. In 1977, the group met just outside of Chicago. Since it was close to home, I went and gave my presentation and did not participate in the full gamut of the organization's activities. This was clearly a mistake that quickly became evident to me as I observed the enthusiasm and camaraderie of the members. I was alone whereas almost everyone else had brought their families. Since that time, I have always thought that the Midwest Surgical Association's emphasis on including the entire family in its program has been what has made this society special. The family is the basic structural unit of any community. By welcoming spouses and children into its programs, the Midwest Surgical Association has served as a glue that binds our professional and personal families more closely together.

Over the last 20 years, I have attended the meetings of the Midwest Surgical Association with my family almost every August. It has become a fixture in our summer calendar, and my entire family continues to look forward to attending, including my children who rarely agree to all go anywhere with their parents anymore. I have often had the privilege of presenting my clinical and laboratory work or discussing that of other members and guests at these meetings. With this track record, one would think I would not have a problem addressing you today. But it is a lot easier to describe what I have done as a surgeon than to explain what I think or feel about the larger issues that surgeons face today. Having already said most everything about my surgical endeavors to this group at one time or another, I will impose a few personal reflections on a captive audience.

The unique way the Midwest Surgical Association intertwines professional and family activities has a very personal meaning for me. My surgical family has wholeheartedly participated in this organization. I have trained under and worked with five of your past Presidents. Robert J. Freeark (1970), Frank A. Folk (1975), William H. Baker (1987), Jack Pickleman (1989), and Gerard V. Aranha (1993) taught me not only how to operate but, more importantly, how to take care of patients. They exemplified the surgeon's responsibility of taking care of each patient with the concern, empathy, and devotion that is given to one's own family. These and many other role models I have had in surgery set a singular standard of care that solely considered what was best for each individual patient. The bond between surgeon and patient is a special human relationship that comes as close to a family tie as any other. The sacredness of this covenant is inculcated into surgeons during their residency training and brought home in their later practice by the question commonly asked by patients and their families, "What would you do if it was your family, doctor?" Treating patients with the same consideration and compassion that we would show our own family is the spiritual conscience and soul of medical practice.

I first began to think of this presentation last summer when I saw the Goodman Theatre's production of Randy Newman's Faust. The story, which is probably known to you, begins with Lucifer being thrown into hell after disagreeing with God. Desperate to get back into heaven, he persuades God to make a bet for a human soul. Henry Faust, a student at Notre Dame University, is the subject of this randomized, prospective, unblinded, computer-assisted study. Lucifer obtains an informed consent by explaining to Henry that he will satisfy his every worldly desire in exchange for

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his soul. Henry's only reply is "What's the catch?" It's easier for good to triumph over evil in the theater than in real life, but even God had to make a few compromises so that everyone could end up saying "You can't keep a good man down."

Later in the year, I attended an exhibition of the paintings of Ivan Albright at the Art Institute of Chicago. One of his most famous works is the portrait of Dorian Grey. This work stems from a novel by Oscar Wilde in which a young man makes a pact with the devil to have his external appearance remain the same, whereas his portrait changes to reflect the licentious deeds and progressive decay of his advancing life. Despite destroying numerous lives with his ruthless self indulgence, Dorian Grey retains his facade of youth and beauty. Eventually he is filled with guilt and shame. However, it is too late to change an entire lifetime of ravage and his attempt to destroy the portrait results in his own self destruction. His judgement day cannot be avoided, and his spiritual dissolution eventually ends in his physical death.

These two works seem to be allegories for the transformation of modern medicine from a very personal profession to a large scale business enterprise. Health care which has traditionally been a noble and honored profession has become a boiling caldron of commercialism, competition, consolidation, and cost cutting. The qualities of commitment, compassion, and concern for our patients' well-being that were once the hallmark of medicine are now being set aside by commerce and financial gain. Although previously considered vices, cunning, conceit, and self-promotion have become virtues in our bottom line driven age. Sports mirror the character of our nation in an embarrassingly deep and true manner. When Rod Tidwell, the fast talking self-inflated football player played by Oscar winner Cuba Gooding Jr. in the movie "Jerry Maguire," screams "Show me the money," the motto of our times was defined.

Health care now accounts for almost 15 per cent of an over $5 trillion economy. No wonder that medicine has attracted the attention of Wall Street and venture capitalists. In 1991, there were 75 Wall Street security analysts covering health care. In just 5 years the number had risen to 381.[1] Venture capital has come pouring in along with this scrutiny, and investment bankers advertise that they have the health care industry knowledge and transaction expertise to get your deal done. In 1992, there were 33 publicly traded health care companies with a market capitalization of $33 billion (Fig. 1). By 1996, this had increased to 144 publicly traded companies with a market capitalization of $140 billion. The changing face of medicine is also seen in the growth of publicly traded HMOs. In 1985, there were slightly more than 10 million people enrolled in nonprofit HMOs. By 1996, this number had doubled to just over 20 million people.[1] Contrast this with the fact that almost no one was a member of a publicly traded HMO in 1985 but by 1996 over 30 million people were enrolled in these for-profit organizations. Chief executive officers (CEOs) of these HMOs earn an average 62 per cent more than CEOs of other corporations of similar size.[2] Apparently they are in a procedure based specialty and not a cognitive one. Physician practice management companies have also grown in this time period with the speed of an undifferentiated neoplasm. Capitalism has been very good to these entrepreneurs. The net worth of the physician

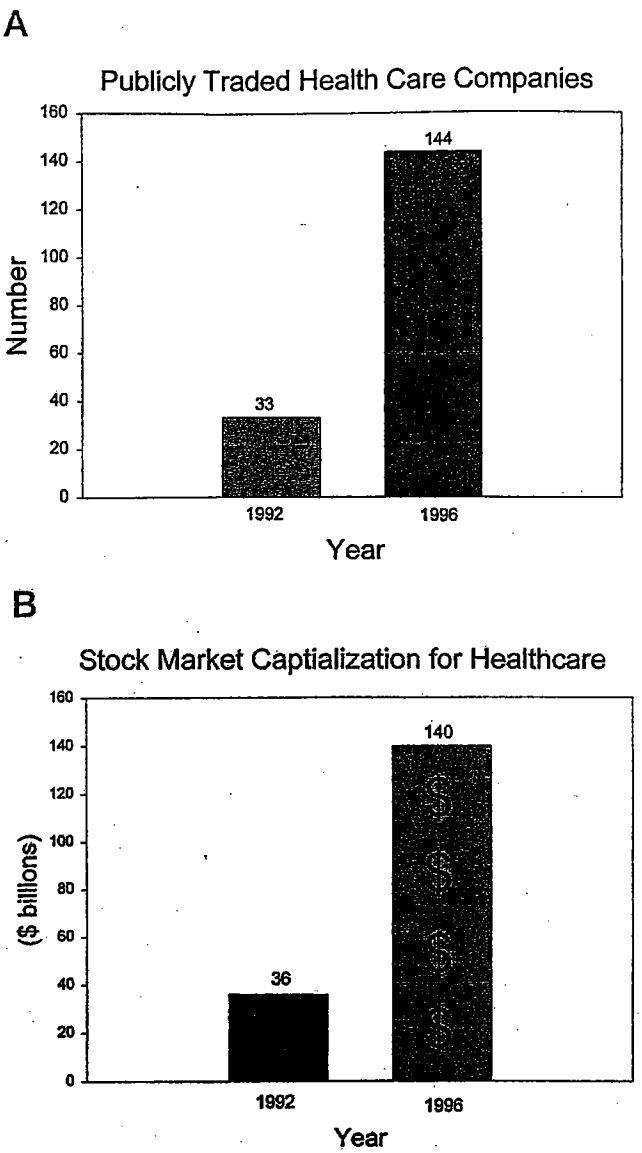

FIG. 1(*A*) The number of publicly traded health care companies has risen from 33 in 1992 to 144 in 1996. (*B*) The stock market capitalization for health care companies has risen from $36 billion in 1992 to $140 billion in 1996. (Modified from *The Rising Tide*, 1996.).

founders and CEOs of these practice management companies is measured in the multimillions.[1]

One of Wall Street's favorite areas has been investor-owned hospitals. These are truly national and even international chains or franchises intent on dominating the marketplace. The largest and best known is Columbia. Coincidentally, the name of this organization is the same used by the World's Fair that took place in Chicago just over 100 years ago. The Columbia Exposition of 1893 expressed its relentless determination by adopting "I will" as its slogan, and this indomitable attitude certainly characterizes this company. Columbia's revenues have grown from $5 million in 1991 to approximately $22 billion in 1996. Its earnings growth, increase in market capitalization, and surging stock price are just as incredible (Fig. 2). Although these aspects of Columbia's evolution are phenomenal, I am even more impressed by their advertisement which I see on a billboard each day commuting home from my hospital. It touts Columbia as the official health care provider for the world champion Chicago Bulls. I am sure the quality of care provided is not improved by this endorsement, but it must be effective in attracting consumers. Endorsement by the Chicago Bulls and their players is a potent marketing tool that few hospitals can afford as they struggle to meet their mission to care for patients. Columbia has an annual advertising budget reported to be about $100 million.

Columbia owns over 350 hospitals, 130 surgicenters, and 200 home health agencies. The numbers are always growing and their web site proclaims a new acquisition on an almost weekly basis. This company has hospital takeovers and acquisitions down to a formula. After a deal is closed the process is begun immediately. Within 30 days, conversion to new distributors and evaluation of outsourcing potential is complete. By day 69, conversion to Columbia's chosen suppliers is concluded. A full-fledged Columbia hospital is up and running within 100 days of its purchase. The completely re-engineered organization is run by modern business methods so that increasing shareholder profits can be generated.

The marketplace can be myopic if not even blind when it comes to promoting social good. The question of whether the growth of for-profit hospitals is good or bad for the health of our nation is not easily answered but is one that must concern us. One view that exposed a corrupting influence of this trend was presented in an article in the *Wall Street Journal* on Friday, May 30, 1997 entitled "Ex-Manager Describes the Profit Driven Life Inside Columbia/HCA." This piece documents the Faustian story of an idealistic young man who graduates from Xavier University with a degree in hospital administration. He starts his career at a Catholic community hospital where management

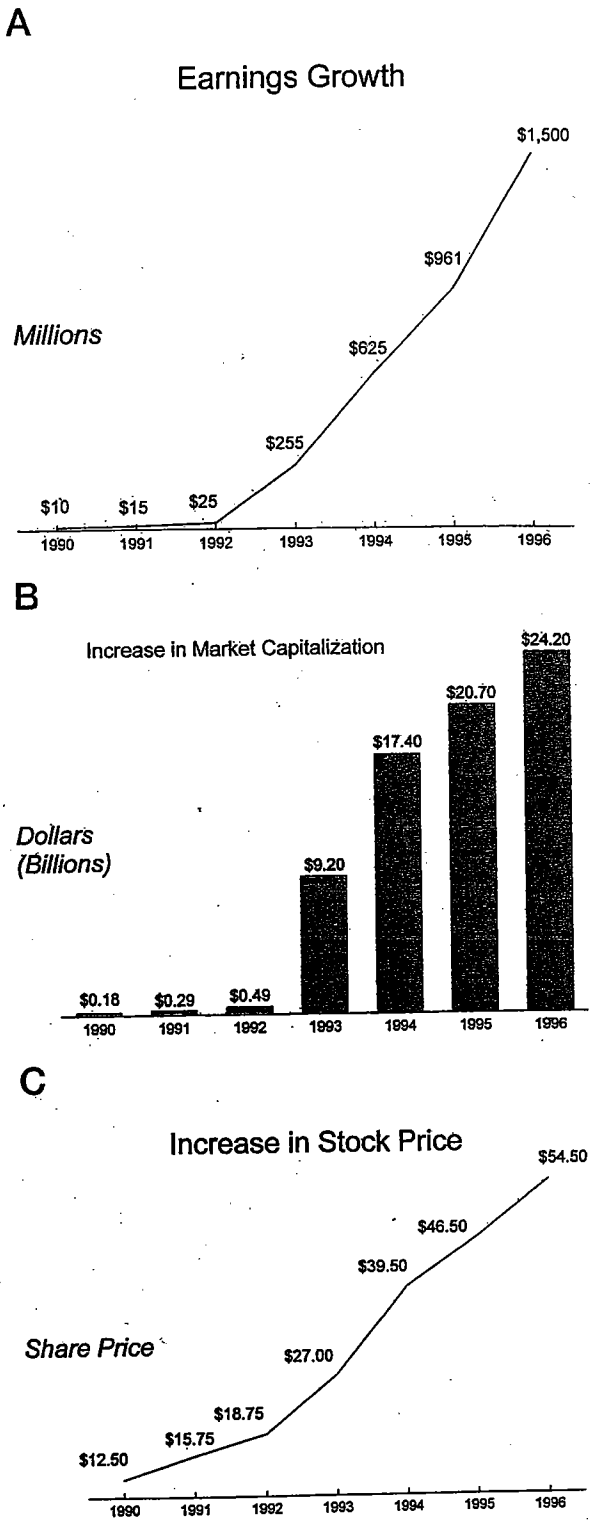

FIG. 2(*A*) The earnings growth of Columbia/HCA has grown from $10 million in 1990 to an estimated $1.5 billion in 1996. (*B*) Its stock market capitalization has increased from $180 million in 1990 to $24.2 billion in 1996. (*C*) The price for a share of stock has risen over 400 per cent from $12.50 in 1990 to $54.50 in 1996.

meetings begin with a prayer. To advance his career he switches to an administrative position at a for-profit hospital. Suddenly he is going to country clubs, wearing designer clothes, and wheeling and dealing. The final transformation of his field of dreams to a field of schemes occurs when this hospital is bought out by Columbia. He zealously takes up the new owner's directive to boost earnings. Although federal laws sponsored by Representative Pete Stark of California bar physicians from referring patients to facilities in which they have a pecuniary interest, Columbia used syndications and other legal entanglements so doctors could invest up to $150,000 in the hospital. This was an effective means to financially tie the doctors to Columbia and to drive their patients into the hospital. Our young manager soon found that his skill at cost cutting and pressing doctors to increase patient volume were the rungs on the ladder of his success at Columbia. Earnings and profits were the forces that drove this hospital manager and eventually resulted in his limiting care for uninsured patients. In his own words, he committed felonies every day to increase market share. No longer able to live with his conscience, he eventually quit his job. He is now writing a book entitled The Columbia Malignancy.

Columbia responded swiftly to this article with a full page advertisement in the *Wall Street Journal* on June 2, 1997. They did not dismiss the story as the grumblings of a disgruntled ex-employee but adopted a positive approach to limit any possible damage to their public image. The ad shows a portrait of Sister Joan, who certainly appears committed to her religious vocation. Sister Joan is a Vice President for Mission and Ethics at a Catholic hospital in West Virginia. She has dedicated her life to serving those in need and to providing quality health care. She enunciates Columbia's commitment to her local community and the health of its citizens by stating, "One thing that is very dear to this hospital is our charity care. With Columbia's partnership, we have really seen our charity care continue and expand." I must admit some skepticism about this portrayal and question whether it is meant to preserve and idealize an external appearance while concealing the corrupting influences beneath the facade. I can only hope that the ideals expressed by Sister Joan play some role in guiding Columbia's every day practices and temper the corporation's acknowledged goal of maximizing investor return.

The economic success of Columbia can be attributed to their purchasing leverage with suppliers that allows them to get the steepest discounts, to economies of scale that come with their large size and to their business culture of compliance that includes physician education and practice guidelines, strict adherence to reduced staffing, and rigid budget discipline. Columbia generates profits from its acquisitions and by enhancing profitability at its existing facilities. Surprisingly, both of these are more dependent on revenue growth than cost reduction. Woolhandler and Himmelstein[3] have shown in a study of 5201 acute care hospitals in the United States that administrative costs accounted for an average of 26 per cent of total hospital costs in fiscal year 1994. For-profit hospitals spent 23 per cent more on administration than do comparable private nonprofit hospitals, and 34 per cent more than public institutions. Likewise, for-profit institutions had higher total costs per inpatient day and per discharge than nonprofit and public institutions. Contrary to the conventional wisdom, their data indicate that a lean mean cost-cutting administrative machine is not the key ingredient for improving a hospital's bottom line profitability.

How does Columbia make money buying up hospitals in shaky financial conditions even if fire sale prices are paid? Wall Street analysts have marveled at the speed in which these hospitals' financial performance is reversed. The answer may be that Columbia knows how to take advantage of a rich uncle. The *Wall Street Journal* reported on June 26, 1997 that the hospital industry's takeover binge has been partly financed by Medicare. According to the Inspector General's Office of the Department of Health and Human Services, federal programs stand to pay out $500 million or more to companies taking over ailing hospitals because of an accounting rule termed "depreciation adjustments." In an analysis of 370 hospital deals since 1990, Medicare adjustments averaged $2.3 million per hospital and in some transactions Medicare payments exceeded $10 million. Although Medicare reimbursement for surgeons continues to be ratcheted down, Columbia has been benefitting from Uncle Sam's largesse.

Columbia's incremental profit growth from existing operations has been phenomenal. In 1995, $175 million more profit was generated from existing facilities. Of this $175 million, 84 per cent was due to revenue growth whereas only 16 per cent was due to cost reduction. Revenue growth means increased patient volume or increased reimbursement. Incenting doctors to admit patients by owning practices, investment syndications, and other perks achieves the former and upcoding procedures and disease severity and eliminating unprofitable services and facilities, or avoiding financially unattractive patients and physicians achieves the latter. Columbia has bucked the trend of stable or decreasing hospital admissions. Although the average number of admissions remained stable at most hospitals from 1992 to 1995, they rose approximately 15 per cent at Columbia. Their business directive is to increase market share of paying customers. Clearly

Columbia has learned that it is not if you build they will come, but rather if you promote it they will come.

Richard L. Scott, a 44-year-old former health care attorney, has been the Chairman and CEO of Columbia. Armed with a sense of urgency and a fierce desire to dominate the competition, he has been widely regarded as a wunderkind for his ability to exploit the turmoil in health care in the United States. For continuing medical education he studies Proctor & Gamble Company for marketing ideas and Wal-Mart Stores, Inc., for merchandising insights. His view of medicine's future was detailed in a *Wall Street Journal* article of May 28, 1997 entitled "Columbia/HCA Plans for More Big Changes in Health Care World." Presently, doctors evaluate and diagnose an individual patient's condition and then decide on a specific course of action. Various medical and nonmedical factors such as the patient's age, associated health problems, level of function, personality, family structure, and other individual concerns are used to tailor a treatment plan for each patient. Mr. Scott sees this as an extremely inefficient method of delivering a product. His grand vision is that diseases from appendicitis to zygomatic fractures will become "profitable product lines" for his business and that the Columbia name will be as global and recognizable as Coca Cola so that it can market its medical services with the slickness of Madison Avenue. Instead of individual physicians planning each patient's care by drawing on a blend of their experience, expertise, and personal knowledge of the patient and their family, a standardized treatment approach would be used for disease management. In this system, information could be punched into a computer and a complete treatment plan would be spit out including type of procedure, length of hospital stay, type and timing of drug regimen, and home care rehabilitation.

This view seems diametrically opposed to what my surgical family taught me and what I try to teach the residents I train. Surgeons do not treat diseases, laboratory tests, or X-ray images. We treat patients and their problems. Our success in doing this is dependent on recognizing not just the similarities in all patients but also the nuances and subtleties that make them different. Dr. James B. Herrick, a Rush professor of medicine who was born on August 11, 1861, wrote that "The doctor may also learn more about the illness from the way the patient tells the story than from the story itself." Paul Pearsall in The Power of Family wrote "One of the biggest mistakes made by modern medicine is to separate the patient from his or her family. One of the biggest mistakes made by our society is the accelerating isolation of each of us from our own primary family systems." Treating diseases like product lines will definitely separate and isolate us from our patients and will adversely effect their health and our ability to improve it.

Both Wall Street and the U.S. government are known to be fickle bedfellows. They can take away as easily as they can give. Mr. Scott launched Columbia by purchasing two nondescript hospitals in El Paso, Texas. Fittingly, a federal inquiry into Columbia's business practices began there in March 1997. As Tommy Lee Jones says in the movie "Men in Black," "The FBI does not have a sense of humor of which I am aware." More than 200 federal agents raided Columbia facilities in El Paso to confiscate documents, computer printouts, and physician office records. On July 16, 1997 FBI agents served 35 sealed search warrants to Columbia facilities in six states. At least four Columbia employees were subpoenaed for a U.S. grand jury in Florida, and indictments have been issued to middle managers. The scope of these investigations are being expanded to other agencies of the federal government and to Medicaid fraud units in several states. The board of directors of this embattled company responded in two ways. First, they obtained Mr. Scott's resignation. It is uncertain whether he received a golden parachute, which commonly occurs in these circumstances. The CEO of U.S. Health Care, an HMO, received a reported $967 million in cash and stocks plus a corporate jet as part of that company's merger with Aetna. The board also began talks to be acquired by Tenet Health Care Corporation, the nation's second biggest publicly traded health care company. This combination would create a company with $30 billion in revenue and almost 500 hospitals from coast to coast. A sticking point for this deal is how to adjust the price tag to account for any fines or settlement charges that Columbia might have to pay the government. An obvious expediency pushing this acquisition is the experience of Tenet chief executive Jeffrey C. Barbakow, who successfully managed the settlement between Tenet's predecessor company and the government over fraud charges in the early 1990s. This saga of present day robber barons is far from over and will continue to affect us and our patients.

I am not naive enough to believe that the economic forces and business interests that have been unleashed on health care will go away. I attend too many meetings that have cost cutting as their sole purpose to believe otherwise. Like Willie Sutton, present day entrepreneurs, capitalists, businessmen, and government regulators have come to our field because it's where the money is. For better or worse, medicine and the market place are bound in a marriage of necessity. We live in a world with finite resources that must be used prudently and efficiently to improve the health of our patients. However, efforts to reduce health care costs that were once out of control in this country must

be patient-oriented and not profit motivated. President Harry S. Truman stated in his inaugural address, "New economic developments must be devised and controlled to benefit the peoples of the areas in which they are established. Guarantees to the investor must be balanced by guarantees in the interest of the people whose resources and whose labor go into these developments."

The essence of our profession was articulated by Hippocrates almost 2500 years ago. The oath physicians have taken ever since clearly places the well-being of patients above financial reward and emphasizes an ethic of service to others. Compromising care to control costs or limiting care to maximize profits destroys our integrity as physicians. Our professional responsibilities also include advancing knowledge and transmitting it to the next generation. Basic and clinical research and medical education are increasingly more expensive, but they are not luxuries that can be eliminated to maximize investor return. They are the means that expand our ability to relieve pain and suffering and improve the health care of future patients. The profits that are being squeezed out of health care were once invested back into medicine to promote medical research and training. Since World War II, medical training and medical advances have been unparalleled in this country. Surgeons skilled in transplantation, open heart, vascular, and minimally invasive surgery are practicing today because of our nation's support of medical research and residency training. If these efforts do not continue to receive the same vigorous support, the improvements in health care that our parents and our generation have come to expect will not be attained by our children and grandchildren.

True, the image of our profession may have been tarnished by the intrusion of aggressive commercialism and competition, but the way to restore the esteem that the public has traditionally accorded us is not by adopting the attitudes of a provider/consumer relationship. Most of us were attracted to medicine and then surgery because of the direct and personal way we could help those in need. We did not attend medical school and go on to residency to learn to make cold hearted callous bottom line business decisions with the cunning of a Chinese general schooled in Sun Tzu's The Art of War. Rather our purpose has been to care for our fellow man with compassion and concern. As William J. Bennett wrote in The Book of Virtues, "Compassion is a virtue that takes seriously the reality of other persons, their inner lives, their emotions, as well as their external circumstances. It is an active disposition toward fellowship and sharing, toward supportive companionship in distress or in woe." Our patients and their families are often facing some of the most trying circumstances of their lives. It is easy to forget this as we rush to get through our over-extended days and work harder for less. Our patients do not need better product lines for disease management but they do need competent and compassionate care delivered in a personalized manner.

The source of deepest satisfaction for all of us who practice medicine is the relationship that develops with our patients, much like the most treasured moments in our personal lives are those spent with our families. The doctor/patient relationship is based on mutual trust and respect. Physicians are obliged to use their knowledge and expertise solely for the best interests of their patients and to act as advocates for their well-being. The level of moral responsibility is even deeper for surgeons because our patients literally put their whole lives in our hands. Crenshaw et al.[4] have stated that the physician/patient relationship is the central element and structure of clinical care: "By its traditions and very nature, medicine is a special kind of human activity—one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self interests. These traits mark physicians as members of a moral community dedicated to something other than its own self interests."

Medicine has never been and should not become a commodity that is governed by the whims of an insensitive market place. What makes health care different from all other service industries is the way that we physicians care for our patients. Our moral credibility is earned by helping others endure the suffering and uncertainty of illness, the grief of painful life events, and the loneliness of death. It is this commitment and dedication to our patients that has earned respect and nobility for our profession. Over 100 years ago Robert Louis Stevenson wrote that physicians stand above the common herd. Doctors earned this trust and respect from previous generations by unselfishly caring for their patients. This dedication and stewardship was expressed in the words of Louis Pasteur that are on a plaque at the base of his statue in the park in front of Cook County Hospital: "One doesn't ask of one who suffers: What is your country and what is your religion? One merely says, you suffer. This is enough for me. You belong to me and I shall help you."

As always, the only certain thing in our professional future is change. We physicians have always readily embraced new developments if they benefited our patients. This must remain the compass by which we judge all future developments in health care. The integrity of our profession rests on our placing the care and well-being of our patients above all else. If our only answer to the challenges of for profit companies like Columbia is to adopt their money making attitudes

we will lose our professional honor and integrity. Cutting nonprofitable services, marketing our product lines, and seeking out higher margin accounts may enhance our profitability, but they will also cost us the soul and character of our profession. We must continue to hold sacred the bond that our patients allow us to share in the physician patient relationship. By caring for our patients with the same compassion and trust that we show our families we will always obtain the most lasting rewards of this honorable profession.

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