Role of Medical Education in Health Care Reform

MARK A. CASELLI, DPM*

Health care reform will have great impact on the podiatric physician as the podiatric medical profession continues to integrate into the general medical community. The role of medical education in addressing five major issues that affect health care reform is explored. These issues include specialization, economics, continuous quality improvement, ethics, and fraud.

Americans spent more than one trillion dollars on medical care in 1994, nearly four times the amount spent on medical care in 1980. By the end of this decade, the medical bill is expected to pass one and a half trillion dollars. This means that by then, nearly one out of every five dollars will be spent on health care.[1] Health care is rapidly becoming unaffordable to an increasingly larger segment of the population. Because of this, health care reform has become a major issue for both the government and private sector.

The two central goals for health care reform include universal health care coverage and expenditure control.[2] To achieve these goals, there must be changes in the current system of health care delivery. Since physicians play a major role in the decision-making process of this health care delivery, it follows that the current method of training physicians needs to be evaluated and modifications made in the medical education process.

There are five major areas that must be addressed in the medical education system. These include: 1) the need for an increased number of family physicians and fewer specialists; 2) greater awareness of the economic issues in delivering health care; 3) use of continuous quality improvement in patient management; 4) reduction of fraud and abuse in administering health care; and 5) greater awareness and appreciation for the moral and ethical issues involved in patient care. Although some overlap exists in these areas, each must be explored, their significance recognized, and changes made in order to achieve the goals for health care reform.

The US has twice as many doctors now as it did 20 years ago, but few Americans can find a family physician when they need one. Many health experts think that in order to provide a good balance between preventive care and more complex medicine, approximately half of all doctors should be family practitioners. Currently, nearly three fourths of all physicians are specialists who do not treat the full range of family medical needs. Only about one in six medical students graduating in 1992 had planned to become a general practitioner, and only one in 12 students still in medical school plans to do so.[1]

The dwindling satisfactions of primary care and the financial incentives to practice procedure-based medicine have encouraged doctors in the US to become specialists, unlike in other advanced countries. In Canada, there exists a 50/50 mix of primary care and specialist physicians, and in Great Britain, 70% of the physicians practice primary care.[3]

The abundance of specialists leads to the frequent performance of diagnostic and therapeutic procedures in situations in which less intensive treatment would have been satisfactory. In addition, since the acute care hospital is the principle training site for specialists, they are more likely to use these very costly sites for patient care, rather than using the far

*Professor and Chairman, Department of Orthopedic Sciences, New York College of Podiatric Medicine, 153 E 124 St, New York, NY 10035; Attending, Department of Veterans Affairs, New Jersey Health Care System, East Orange, NJ; private practice, Ramsey, NJ.

less costly ambulatory care sites, the domain of the primary care physician.[2]

There are many factors that contribute to the overwhelming desire of medical students in the US to become specialists, not the least of which is their earning potential. After years as underpaid and overworked residents, medical students expect to enter a lucrative profession. Surgeons, whose average income is $260,000 a year, earn more than twice as much as general and family practitioners, whose average annual income is $115,000. Some surgeons make millions of dollars a year, while a quarter of the family practitioners make less than $75,000.[4]

Another major force that contributes to the predominance of specialists is the fact that the leading research-oriented academic health centers that set the style and pace for medical education have concentrated on the training of specialists and subspecialists. Many prestigious medical schools have failed to establish a department of family practice, and do not offer a residency in family practice.

Since the field of specialization, location of practice, and type of practice are largely under the control of the medical student, there are many competing factors and forces that enter into making that decision. These include the individual's preferred field of medicine; the differential earnings potential among the different specialties; the length of time the individual is willing to invest in graduate medical education; the individual's accrued debt at the time of graduation from medical school, and the amount of earnings needed to liquidate them; and the individual's preference of location and mode of practice. In an environment where specialists are generally the physicians of choice for the more affluent sectors of the public, are reimbursed more than generalists, and have greater prestige in the medical community, there is little doubt as to why there is an overabundance of specialists.[2]

These issues must be addressed to change the trend away from specialty training and to the selection of training in primary care medicine. Paramount among these is a need for significant changes in the financing of undergraduate medical education to avoid the accumulation of large debts by medical students.

Australia has found a way to encourage more of its medical students to choose family practice by providing free medical education. In this manner, physicians begin their careers without heavy debt and are under less financial pressure to specialize in higher-paying fields of medicine. Although US taxpayers already pay approximately five billion dollars per year to subsidize medical schools, currently only a tiny fraction of that money is providing education for family physicians.[1] A shift in the distribution of this resource could be used to encourage careers in family practice.

Other incentives to create more family physicians might include the federal government's intervention in the financing of graduate medical education, by using its annual multibillion-dollar flow of Medicare funds to shift the balance between generalist and specialist residencies. Finally, substantial revisions would have to be made in the payment schedules for practicing family physicians.

The other major areas that must be addressed during the education of physicians include a greater awareness of health care economic issues, use of continuous quality improvement in patient care, avoidance of fraud and abuse, and a greater awareness and understanding of the moral and ethical issues in patient care.

Physicians make at least 80% to 90% of all health care decisions. While their direct personal compensation, after overhead and expenses, probably runs only about 12% to 15% of the total health care bill in America, these decisions made in favor of more extensive care significantly increase the overall cost of care for each patient. When a child has repeated ear infections, for example, a physician is often faced with a choice between continued use of antibiotics (with an office-visit fee of approximately $35 to $70) or performing a myringotomy in the hospital at a charge of $500.

There are several issues at play in this scenario that should be explored at every level of a student's medical education. Clearly, the ear-tube surgery not only pays the doctor more, so there is a profit motive, but it is often considered a more glamorous and prestigious form of medicine. It must be emphasized to the student that there is also a significant body of evidence among physicians that not all ear-tube operations currently being performed are necessary, and that continued antibiotic use would be safer and less expensive. There must also be an awareness that the major difference in cost is not the doctor's fee, but is for hospitalization. A 2-day hospital stay could easily cost the insurer (and, ultimately, the consumer) another $2,000 to $3,000 in a moderately priced hospital.[5]

Another concern is the physician's fascination and subsequent overuse of high technology. Physicians admit, for example, that the introduction of magnetic resonance imaging machines in the 1980s led initially to vast overuse, even more so after consumers read about them and demanded the new $1,000 test. The same pattern has held for other diagnostic advances. In the case of prenatal tests, expectant mothers now expect to see "baby's first picture" on a sonogram. As a result, costly sonograms and fetal monitors are

used out of proportion to the actual incidence of evidence that they are needed. One 1993 study estimated that one billion dollars in useless sonograms is being spent every year, in part because patients have come to expect them.[1]

Another issue is that Americans devote enormous resources to fighting off death and battling the final stages of disease. Nearly one third of all US health care costs, a total of about 300 billion dollars each year, is incurred treating people who are in the last 6 months of their lives. Those patients include people struck by catastrophic injury and illness, and millions of elderly Americans who will die despite the heroic efforts of their physicians. Similarly, 35% of Medicare spending, or about 45 billion dollars, is spent on futile care, a reference to medical help that cannot possibly save patients or significantly extend their lives.

The problem lies in the fact that Americans live in a can-do medical environment whereby, if there is a procedure available, it is done. An example of this is the case of a geriatric patient in the final stages of her life dying of cancer. The doctors wanted to amputate her leg. When she asked her son what he thought, he told her to go home and be with his father, rather than go through another procedure. Much of this sort of futile treatment is pointless, as well as unnecessarily painful for the patient who might otherwise die more peacefully.[1]

Issues like these involve not only an awareness of the economics of health care, but also an understanding of the moral and ethical issues involved, as well as the application of continuous quality improvement to these health care situations.

In a system with a continuous quality improvement focus, the concern would be whether or not the patient's real needs were met by the entire process and not just a single incident of care. The health care provider must focus on the patient and not the medical technique to produce a noticeable change for the future.[5] These concepts must become an integral part of the training process of physicians to make a real difference in health care delivery, and not be instituted after the physicians have already developed a philosophy of treatment.

As much as 75 billion dollars in health care spending is lost every year to outright theft and fraud. When one of the largest insurance companies surveyed its customers, two out of five patients said they knew that their doctors had cheated insurance companies, generally by exaggerating their medical problems in order to qualify for high reimbursement. A patient who visits the doctor with a bad cold, for example, might not be reimbursed, but if the doctor calls the problem "gastroenteritis," both doctor and patient will benefit when the insurer pays.[1]

Although it is questionable whether or not morality can be learned, if issues such as the one described are not discussed and evaluated by the young medical student, it may be considered as merely the way in which medicine is practiced, and in some cases, even beneficial to the patient. The total impact of these decisions, both for the doctor and on the economics of health care, must be explored early in a medical career. It would be important to note, for example, that even under the centrally controlled National Health Service in Great Britain, approximately 30% of all elective surgery is performed outside the government system, the patient accepting the fact that not all medical care is covered by insurance.[2]

Some may argue that the free enterprise system, with its managed health care HMOs and PPOs, will force the resolution of the problems and the doctors will therefore, out of necessity, fall into line. The bottom-line focus of these companies is to compete successfully in the market place, hold down costs, and produce dividends and higher stock prices for shareholders. Their concentration on short-term profits gives executives little incentive to invest in long-term health. The legal duty of corporate executives is not to serve all people fairly, but to serve up profits for investors. Doctors are not being put in the position of protecting the public good, by limiting access to expensive care, but are being asked to safeguard corporate earnings, either at their expense or at the expense of their patients.[3]

A change in the way medicine is practiced is required to meet the financial constraints that face the US health care system in the future. The only way this can be accomplished, without undermining the standards and morale of the medical profession, is through a change in the way medicine is taught to future physicians by our medical schools and residency programs.

The concept that the family practitioner is the keystone, and therefore, the most important member of the medical community, must be clearly established during "day one" of the medical student's education. Economic, moral, and continuous quality improvement issues should not merely become part of the medical students' education, but must be given as much or even more emphasis than any of the other basic science or clinical areas. By initiating this educational directive, these important areas of health care will become part of the practice of medicine, rather than just an afterthought or transient concern, and thus can lead to a long-lasting solution to the health care needs of the future.

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