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On Timeless Principles in Changing Times

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Significant social change seems to come not from Washington D.C., but is born in California, redefined in the East, and arrives lastly in the South. I am a son of the South. I was born, raised, and educated there. I have never lived anywhere else. For the past 18 years, I have lived and worked in the deep South. That adjective deep has both geographical and metaphysical connotations. The first question an Easterner will ask you is, "What school did you attend?" The first question a Northerner will ask is, "What do you do for a living?" The first question a Southerner will ask is, "Who was your Grandfather?" In general, societal change in the deep South is something to be resisted as both unnecessary and unwanted. It comes only gradually. If it comes too quickly, it can be met with violence and is the result of legislative mandate or economic necessity.

In the past year or so, significant societal change has come to Savannah, Georgia in the form of managed health care. Hospitals have purchased physician practices, other smaller rural hospitals, home health care agencies, and other related health care businesses. Large employers have joined together and have negotiated contracts with hospitals and groups of physicians to deliver care to their employees at a reduced charge. Physicians have joined under the banner of one or more of the hospitals in preferred provider organizations and physician hospital organizations. Specialists who were once long-time competitors have merged their practices and become associates so as not to be excluded from these provider organizations. Care plans for high-volume diagnostic-related groups are being developed. Capitated contracts for care are being sought and negotiated. Patients go where they are told and not always where they would choose. The relationship between the medical staffs at the different hospitals is not exactly cordial. Things have changed and changed rapidly; not because of legislative mandate, but out of economic necessity or, more precisely at this point, economic uncertainty. There has been no law passed, no period of violence, and no carpetbaggers. One thing is for certain, change has come, and it seems to be only the beginning and it seems to be permanent. I would say with much confidence that all of this sounds uncomfortably familiar to you. You have already experienced these changes and probably know better than I what personal impact they have. But what concerns me the most is not the personal impact, but those things about which I have heard little and read even less, that being what is the impact of this change in health care delivery on trauma systems, resident education, clinical research, and scientific organizations such as ours. Somewhere the key element in this change and in our work, the patient, seems to have been relegated to an afterthought. The system has been so influenced by economics that somehow the patient has become secondary. Make no mistake, managed care is all about money. The operative word in managed care is not care. Who speaks for the patient, and what principles should guide us through these changes?

Legislative health care reform failed in the last session of Congress, but no one predicts that it is forgotten. It too will come to affirm this private sector initiative. Health care reform is no longer a Damoclean sword in the West. The tocsin has sounded for the fee-for-service system. The invisible hand of the great capitalist Adam Smith has applied standard business practices to medicine and placed a fourth party, the HMO, in our midst. More than 50 million Americans are currently enrolled--a number worthy of our most serious consideration.

Significant changes in the health care work force have been proposed that will reduce the number of specialists and increase the number of primary care physicians. Some have called for a reduction in the overall number of residency positions to 110% of the number of current graduates of United States medical schools. No one predicts the number of residency positions in general surgery to increase above current levels. Everyone foresees the number of surgical subspecialists decreasing.

Surgical residents and fellows are the essential mortar of patient care and scientific research in academic teaching hospitals. Any change in the surgical work force in this country must consider the funding for graduate medical education and research. Since 1965, graduate medical education has been funded through Medicare. The direct costs of resident salaries and administration of the teaching programs, as well as contributions to faculty salaries, are calculated by the teaching hospital and reimbursed to that hospital by the Health Care Financing Administration. Teaching hospitals also receive an increase in the percentage of Medicare reimbursement based on the number of Medicare patient days to cover the indirect expense of medical education. Both have been significantly decreased. No one predicts that funding for surgical programs will increase.

The recent Republican takeover in Congress will more likely approach the federal budget deficit by decreasing expenditures rather than by increasing tax revenue. The three most likely candidates for reduction are defense, social security, and Medicare. Which one do you think will be cut? The teaching hospital that bears the burden of graduate medical education and usually the lion's share of indigent care cannot compete in a purely price-sensitive environment. Capitated contracts for Medicare patients have the potential for destroying the academic teaching hospital unless changes in funding mechanisms occur. All payers of health care, not just the federal government, should be required to support financially the missions of graduate medical education and medical research.

General surgery is the father of trauma surgery. Our ranks are replaced by residents in general surgery. If managed care will reduce the numbers of surgical specialists, then managed care will reduce the number of trauma care specialists. There are no alternate health care providers that can take their place. No primary care physician can do what we do, and there is no indication that serious traumatic injury will suddenly decrease. Organizations such as ours need to look back to and support our source: general surgery. The underlying principle herein is that the state of excellence in American health care, which no one denies, is the result of our graduate medical education system and the research it engenders. To in any way harm the latter deters the former.

The decade of the 1970s saw the development of regional trauma systems. In the 1980s these systems grew throughout the country and were improved. The 1990s will see challenges to this progress in the form of managed care. The principle of treating the severely injured patient in a facility that has the resources and personnel immediately available to offer the best possible outcome for the patient is well known to us. It is in fact our underlying credo. If, or more appropriately I should say when, economics becomes a factor in triage, when authorization for care is a prerequisite to reimbursement for care of a severely injured patient, then our past progress is lost. When payment for care of the seriously injured patient is limited or denied because that patient was cared for in an appropriate facility by the appropriate physicians and not by the contracted hospital or contracted physicians, then we will suffer. If the decision to transfer from the trauma center back to the contracted facility is not the sole decision of the treating trauma surgeon, then the system will suffer, and more importantly, so will the patient. The American College of Surgeons has developed a statement on managed care and the trauma system that offers guidelines to avoid these problems. The Eastern Association for the Surgery of Trauma (EAST) should strongly consider public support of this or a similar stance. We felt strongly enough to develop such a position paper on the impact of violence in America, and I would propose that the impact of managed care on trauma systems also deserves such recognition by this Association.

No one predicts that surgeon's income will increase in the managed care environment. The incentive will be for the teaching faculty to increase revenue further from patient care at the expense of teaching and research time. The cost of travel and registration fees to meetings such as this will become more and more of an issue. Couple that with the possibility of a decrease in our numbers and you can see that this organization too will feel the effects of change. Perhaps it is time for EAST to remove its geographical restriction on membership and expand its number of associate memberships in related disciplines. Such a move would offer both a stronger voice and a broader scientific scope to the Association. At the same time, a more cost-conscious and cost-efficient organizational structure could evolve by development of an administrative secretary position and permanent home base. Perhaps its time for EAST to consider a broader range of revenue-producing endeavors; endeavors that would be within the scope and spirit of our charter. Examples of such projects would be the Abdominal Trauma Sonography Course at this meeting, the Trauma/Surgical Critical Care Self Assessment Program currently under development, and the slide sets on violence already available. These ideas and others should be placed before the membership, and, if approved, enacted by the Board. However,

no course of action should be against our principal mission of nurturing the young trauma surgeon within the friendly and family character of EAST.

It has been said that physician resistance to managed care is based solely on a potential decrease in their personal income. I cannot and will not agree. Trauma surgeons, perhaps more than any other group of physicians, offer the proof that altruistic purpose and not economic pursuit is still the guiding principle in medicine. When presented with a seriously injured patient, the trauma surgeon seeks the diagnosis and sets into action life-saving interventions based on patient need and not on the patient's insurance status or ability to pay. Only later, and usually much later, is the patient's insurance status or even identity known. The most surly unemployed indigent bank robber is given the same high level of care as the most wealthy bank executive. It is the nature of the specialty, and it is the nature of this particular specialist. Success not access is our major issue. So, when it is said that physician reluctance to change may be based on economic interest and not patient gain, let the trauma surgeon speak out and hear the truth.

If your approach to this veritable revolution in your profession is to ignore it, then you are lost. If your approach is to be guided by the experts, then consider this. We are the experts in trauma care, we are the leaders in trauma care, we know more than anyone what is best for the trauma patient. If you truly believe that, then you are obligated by your position to become involved with these issues. We must ensure, by speaking out both individually and as a group, that the trauma patient, the trauma surgeon, and the American trauma system will not suffer from these changes and continue to serve as the example for the rest of the world.

Like blue jeans, fast food, and rock and roll, the managed care concept is uniquely American. This fourth party has been added to the physician, patient, payer relationship to glean profit and guard against system and physician excess. But qui custodes custodiet?--Who will guard the guards? Who will ensure the future of quality graduate medical education in general surgery and trauma surgery? Who will ensure that quality surgical research will continue to advance? Who will ensure that the progress gained thus far in trauma systems and trauma care will not be hindered? Who will ensure that cost containment does not include care curtailment? And, who is rightly responsible and obligated to speak out on the patients' behalf? You already know the answer.

My highly valued friends, I ask you to think back for a moment? What is it that caused you to enter medical school? What is it that made you endure those many years of surgical training? What is it that stimulates you to be up at three in the morning suddenly faced with horrendous, life-threatening injuries? What is it that gives you greatest professional satisfaction? It is the business of patient care, not the patient care business.

The changes in health care delivery that are occurring will cause you to make many critical decisions about your practice and your life. In all of your decisions, clinical or financial, place the interest of your patient uppermost and thereby stay true to yourself and your heritage. It is clear that you, the physician, are the timeless principal in these changing times.