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Turning Doctors Into Employees

By Matthew Anderson

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"No," said the priest, "it is not necessary to accept everything as true, one must only accept it as necessary. A melancholy conclusion," said K. "It turns lying into a universal principle."

--Franz Kafka, *The Trial*[1]

Much of the contentious debate surrounding the Patient Protection and Affordable Care Act ("Obamacare") concerned its financing and its attempt to guarantee (near) universal access to healthcare through the private insurance market. Aside from sensationalist stories of "death panels," much less attention went to implications of the bill for the actual provision of healthcare.

Few noted that the Affordable Care Act (ACA) – attacked from the right, favored by Democrats – continues historical trends towards consolidation of a medical-industrial complex (MIC),[2] which now controls nearly 18% of the Gross Domestic Product (GDP) and is hungry for more.[3] Key to its project is control over the daily activities of the physicians and other licensed healthcare professionals who are legally sanctioned to make decisions concerning and administer various interventions. This control is usually framed as an effort to produce greater value (to improve both efficiency and quality of care), as part of an effort to bring "market discipline" to an overly-expensive, irrational, and inefficient system.

I propose that such concepts—value, efficiency, quality, and market-discipline—are part of an ideology designed to justify corporate control over the work of physicians. In describing the "deprofessionalization" of healthcare workers, it may be helpful to keep in mind Marx's concept of alienation – the separation of the worker from the control and the product of his or her labor – as a useful way of thinking about the clinician of the future, who must learn what it means to become an employee.

The Medical-Industrial Complex

The concept of the medical-industrial complex has a long history in struggles over healthcare. It emerged in the 1970s from the Health Policy Advisory Center (Health/PAC), a group of New York City activists.[4] Then, as now, healthcare in the United States was perceived to be in a crisis; then, as now, that crisis was framed primarily in terms of costs. And with good reason. In 2012 the United States spent $8648 per capita on healthcare, representing 17.9% of the GDP.[5] The Organisation for Economic Co-operation and Development (OECD) estimates from 2009 show that the United States spent far more per capita ($7960) on healthcare than country #2 (Norway at $5352) and more than double the OECD average ($3233).[6] Despite this enormous investment in healthcare, U. S. health indicators are not particularly good; the United States ranks 33rd in terms of life expectancy.[7]

The trouble with this critique of U. S. healthcare is the assumption that its deficiencies stem from its being a "non-system." Health/PAC considered this a false assumption since it was based on the idea that "the function of the American health industry is to provide adequate healthcare to the American people." However, "[w]hen it comes to making money, the health industry is an extraordinarily well-organized and efficient machine."[8] Rather than patient care, Health/PAC saw the main functions of the medical system as being profits, research, and teaching; social control is also mentioned. The deficiencies of our healthcare system – and they are numerous – should be understood as an inevitable by-product of emphasizing the pursuit of profit.

The MIC has only grown since the 1970s and its functions are carried out by large and politically powerful business sectors: the pharmaceutical industry, the health insurance industry, healthcare delivery systems (typically built around hospitals), specialized clinics (e.g., dialysis centers), equipment and supplies, healthcare worker salaries, pharmacy benefits managers, nursing homes, health information, home health agencies, research and biotech firms, medical informatics, medical schools, etc. It is no coincidence that in 2013 the healthcare sector was the top spender on political lobbying (nearly $360 million).[9]

In the remainder of this essay I will explore just how the corporate model is degrading the culture of clinical care and the work of clinicians. We will see what happens when the business model of medicine enshrines the centrality of health as a commodity and self-interest as a motivator: the mission of the margin overtakes the mission of healing.

The Sorry State of U. S. Primary Care

There is strong evidence to suggest that primary care improves the health of populations and that, unlike specialty care, it helps reduce health disparities. Primary care is also cheaper than specialist care.[10] There is even some U. S. evidence suggesting that an overabundance of specialists can be bad for community health.[11] Yet, despite the demonstrated benefits of primary care, only 35% of U. S. doctors work in it. The majority of our doctors are specialists.[12] In Europe, by contrast, primary care doctors more typically make up 70% of the physician workforce.

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The reasons for the specialist-heavy U.S. system are complex but they bring us back to the technology and profit-driven character of the U. S. healthcare system. It rewards new physicians for choosing high-tech, expensive procedural-based specialties (such as orthopedics and cardiology) rather than the more cognitive and relationship-based specialties of internal medicine, family medicine, and pediatrics. Medical students quickly learn to

see primary care as bringing low prestige and low pay.[11] There is no particularly good reason why primary care work should be undervalued. The essence of this problem is a political one: specialists run our academic medical centers, have close financial ties to industry, and have been able to define medicine and healing as the use of expensive wonder drugs and high technology.

The Patient-Centered Medical Home: Neither Patient-Centered nor a Home

In the past decade a new model of primary care, the Patient-Centered Medical Home (PCMH), has been promoted to solve the problems of primary care. The term "medical home" appeared initially in 1967 in the pediatric literature. It was designed to describe a place (a "single source") where a child's medical records would be kept.[12] In the 1990s the idea of the medical home was elaborated within the primary care community; e.g., by the American Academy of Pediatrics in 1992 and 2004, the American Academy of Family Medicine in 2004, and the American College of Physicians (internists) in 2006. This culminated in a joint statement issued by five primary care organizations in 2007. By 2008 a National Committee for Quality Assurance had promulgated standards for a PCMH, adherence to which guaranteed extra reimbursement for providers.

AN ACTIVIST WITH PHYSICIANS FOR A NATIONAL HEALTH PROGRAM AND A RESIDENT IN A SOCIAL MEDICINE PROGRAM BEING HANDCUFFED DURING OCCUPY'S FIRST ANNIVERSARY. PHOTO COURTESY OF MATT ANDERSON

It is difficult to define exactly what a PCMH is because various organizations have promoted different conceptualizations.[13] But some of the components include better integration of healthcare, usually accomplished through electronic medical records (EMRs); the creation of health teams, as opposed to solo practices; improved patient access to care; a personal physician for each patient; and efforts to improve the quality of care as measured by standardized targets. To address pay disparities, primary care physicians are promised increased income when they meet certain standards of quality; this is known as "Pay-for-Performance" (P4P).

While none of these initiatives are necessarily bad, they address symptoms of the problem, not the problem itself. The flow of resources into (expensive) specialist care continues, as does the underfunding of primary care. If population health is the goal of the system, this makes little sense. However, if we understand the imperatives of profit, it is both logical and inevitable.

The PCMH is a vehicle for the delivery of health services organized through a competitive, private insurance market; this is the heart of "Obamacare." Purchasers of health insurance – individuals or organizations – are expected to make a yearly decision regarding which plan is most advantageous in terms of price and benefits. Adopting the "home" metaphor, it is a bit like getting the opportunity to move once a year and find new family members. Even if patients want to stay "home" with their current doctor, there is no guarantee that their doctor will be on the company-offered plan next year. Let us be clear: this is a business model, not a home. For that matter, the development of the PCMH was not really "patient-centered." Professional societies and large corporations developed and promoted the model. Patients have not been centrally involved in its conceptualization or in its elaboration. The PCMH is "patient-centered" only in the sense that McDonald's is "customer-centered."

Ironically, the hype and fanfare surrounding the development of the PCMH model seem to arise from the demise of personalized healthcare rather than the dawn of a new era in primary care.

Pay-for-Performance (P4P)

One pillar of the PCMH is the P4P program, in which doctors receive monetary rewards for hitting specific, quantitative, clinical goals: e.g., percentage of patients with flu shots. Studies of P4P have shown widely differing effects of individual P4P programs on quality measurements.[14] In other words, we do not really know if it works. If P4P were a pill, this lack of evidence would have prevented its approval or use. But the business world is different. Its ideological imperative to turn healthcare workers into employees is powerful.

P4P's lack of success may result from the direct undermining of what has always been conceptualized as the central concern of the physician: the welfare of his or her patient. When patients ask me whether or not they should have a flu shot, they are asking me for a disinterested answer based on my professional opinion and my knowledge of them. How would they feel if, as honesty demands, I told them I was getting some amount of money (no matter how small) every time they got a flu shot? It would destroy the very trust that should be the foundation of our relationship.

Such measurement programs can also be faulted on more practical grounds. Usually they rely on easily measured goals: number of shots given, blood pressures, cholesterol measurements, patient-satisfaction surveys, and so on. But many of us feel that the heart of primary care involves relationships that are created over time with families, a factor that cannot be reduced to a number on a scale. When I visit my patients in the hospital – a familiar face in a frightening and strange environment – I provide a type of caring that is central to the role of a healer but is invisible to the highly technical world of "hard" targets.

Patients remember these visits and thank me for them years later, when I perhaps have forgotten them.

In addition, clinical targets are notoriously fickle. Clinical medicine evolves rapidly and what is good today will be seen as substandard in a few years. Goals for blood pressure, cholesterol, and diabetic control have undergone major revision in the past several years in ways that P4P programs either cannot or do not capture. And as more and more clinicians work in larger institutions, the attribution of clinical outcomes to any individual clinician becomes increasingly problematic.

Truly "patient-centered" medical care would require great flexibility in terms of clinical outcomes. Not all patients want all treatments. The externally generated quality targets may not reflect the real problems facing the patient, the clinic, or the community.

Enter the Electronic Medical Record (EMR)

The Bush Administration initiated a large federal initiative to promote the use of health technology and, specifically, electronic medical records. This initiative received further impetus during the first year of the Obama administration, when medical practices were given incentives to purchase EMRs under the American Recovery and Reinvestment Act, the 2009 stimulus package.[15] Again, EMRs were an interesting idea without much evidence of either harm or benefit. They were also an interesting new, federally subsidized profit center and dozens of vendors came forth to sell their EMRs to clinicians.

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The result, ironically, may be that health information has become more fragmented. Four years later we have a bewildering variety of EMRs, none of which talk to each other; within individual institutions there are often several different EMRs. Sorting out this chaos – created in the logic of a market place – may take decades. Who knows how many people will need to get extra vaccines or extra tests because their records are lost in some now-obsolete and inaccessible software? The "medical home" seems to have been colonized by various unruly families none of whom speak the same language.

There are other troubling features of EMRs.[16] Most were designed to capture billing and quality information, not to facilitate clinical care. As a result, clinicians, rather than looking at their patients, sit hunched over their computers clicking little boxes indicating they have advised their patients not to smoke or that they need a colonoscopy – a clear example of alienation. As one frustrated patient told me: "I used to talk to my doctor; now I just see the back of his head." There is no particular rhyme or reason behind the flow of a clinical interview, since it now follows computer generated prompts. As one works one's way through the required screens with the required answers, one might as well be standing behind a Burger King counter and noting if the customer wants fries or onion rings.

Not only is the voice of the doctor gone in many EMRs, more crucially, so is the voice of the patient. In a menu-driven EMR, clinical histories are reduced to a random collection of facts taken out of context: *left abdominal pain / quality: crampy / duration: 2-4 days/ relieved by: defecation*. This is almost anti-medicine, i.e., a deliberate perversion of the essential task of creating a meaningful understanding of the patient's experience of illness as both a diagnostic and therapeutic tool.

"We Strive for Five": Manufactured Satisfaction

One of the most pernicious aspects of the PCMH is the focus on massaging data to meet targets, a corruption of the very knowledge that should be the lifeblood of improvement. This is seen in the approach to satisfaction surveys, such as the Press Ganey *Improving Healthcare* "product."[17] Press Ganey sends surveys on quality of care to a sample of patients after visits. Mid-level managers are put under intense pressure to get and maintain good survey scores. In order to boost scores, a message that "We Strive for Five" (fives are the highest) is often presented to patients either on posters, on appointment cards, or verbally by staff. If this does not work, Press Ganey can be contracted to advise the institution on how to improve scores, an interesting side-business for an agency that is supposed to provide impartial ratings.

Letting patients know that their doctor or clinic wants a "five" rating introduces a not-so-subtle bias into their answers. It is exactly the kind of thing we would scrupulously avoid in clinical research. A principal investigator who chewed out his or her research nurse because the blood pressure results were not as expected would be fired. A mid-level manager who does the same is rewarded.

This is a perfect illustration of a dictum coined by American sociologist Donald T. Campbell which has come to be known as Campbell's Law: "The more any quantitative social indicator (sometimes even a qualitative indicator) is used for social decision-making, the more subject it will be to corruption pressures and the more apt it will be to distort and corrupt the social processes it is intended to monitor."[18] The massaged results of the satisfaction survey impede real attempts to improve systems. Of course, system improvement may be irrelevant, as long as money is being made.

Sleeping with the Enemy: Professional Associations

The conquest of primary care by the medical-industrial complex and its PCMH model has occurred with the complicity of physicians who head the professional organizations of primary care, and whose leadership is compromised by commercial interests. Two examples: first, the American Academy of Family Physicians has chosen Coca-Cola to be a corporate partner; visitors to FamilyDoctor.org will see an ad for Coca-Cola at the very top of the website. Second, the American Academy of Pediatrics (AAP) endorses breast-feeding as the optimal form of infant nutrition, but nonetheless allows the makers of Enfamil (a breast milk substitute) to sponsor its continuing medical education activities; and the AAP logo is prominently displayed in periodicals advertising baby formula. Advertising of breast milk substitutes is illegal in most countries. Even the National Institutes of Health has corporate partners, which have included both Pepsi and Coca-Cola. One pities the poor patient who must make sense of the fact that her doctor and her government, both charged with protecting health, are proud partners of Coca-Cola.[19] Coke can't be all that bad, can it?

The Central Role Played by Medical Schools

As noted by Health/PAC in the 1970s, academic medical centers play a central role within the medical-industrial complex. They train the physician work force and mold its professional values. They conduct much of the research that fuels technical advances in medicine. And they promote specific social constructs (such as a genetic or racial basis for disease and social problems) that create social consensus. The academics who run this system are highly rewarded. In many large universities, the highest paid officials are the basketball coaches and the head of the teaching hospital.

Medical students have often been important activists in promoting change. Harvard Medical School itself is an interesting case in point. In 2008 a variety of high-profile conflict-of-interest cases came to light at Harvard. Medical school students themselves formed a group to protest the fact that so many of their professors had undisclosed industry ties.

This problem is typically conceptualized in terms of "conflicts of interest" which need to be disclosed and regulated. But industry is so interpenetrated with academia that their relationship is best described as symbiotic. For example, in 2007 Eric Campbell and his colleagues at Harvard Medical School published a survey of department chairs at U.S. medical schools. Of the 688 chairs surveyed, they received a response from 459 (67%). They found that two-thirds of the department chairs had a direct personal tie to industry. These ties came in a variety of forms, with the most common being consultancy (27%) but extending to direct roles in the corporation either as officer (7%), founder (9%), or director (11%).[20] Over two-thirds reported that these relationships had "no effect on their professional activities." This is a fascinating finding. What types of "non-professional" activities do department chairs do with corporations?

On the other hand, medical students have often been important activists in promoting change. Harvard Medical School itself is an interesting case in point. In 2008 a variety of high-profile conflict-of-interest cases came to light at Harvard. Medical school students themselves formed a group to protest the fact that so many of their professors had undisclosed industry ties.[21] On a more national scale, the American Medical Students Association (AMSA) has played an important role as an advocate for change. AMSA was created by medical students in 1950 as a progressive alternative to the AMA-sponsored medical student organization. In fact, former AMSA members were central to the creation in 2005 of the National Physicians Alliance, which was conceived as a progressive alternative to the AMA. AMSA regularly surveys medical schools regarding their involvement with the pharmaceutical corporations and hands out grades ranging from As (25% of schools in 2013) to Fs (8% of schools).[22]

But can relationships with industry really be "managed" in any meaningful sense of the word? When in 2011, Dr. Laurie H. Gimcher, a Harvard University immunologist, was made Dean of the Weill Cornell Medical School (WCMS), it was revealed that she had ties to two of the world's largest pharmaceutical companies: Merck and Bristol-Myers. She was on the Board of Bristol-Myers, a position that paid her $244,500 in 2010 and some $1.4 million in deferred stock options.[23] Rather than seeing these ties as a problem, the university took the exact opposite view and argued that: "these outside jobs are crucial to advancing one of its long-term goals for WCMS: dramatically expanding its partnerships with industry."[24] This argument clearly expresses the ideals of the MIC where there is a seamless union between academia and business.

The Importance of What Is Not Mentioned

The PCMH was designed to address serious problems in U. S. healthcare: lack of integration, rising costs, problems with access and quality. While I have noted some of its shortcomings, it is also important to remember what the PCMH cannot address and what options it does not explore. There will continue to be tremendous class and racial biases in the system; these impact quality and access to care as well as access to careers in medicine. Such omissions follow from the premises of the MIC. In addition, a system that is highly incentivized to hit quality targets may want to avoid poorer (or sicker) patients whose outcomes are not so likely to be good.

Many models of clinical care have sought to make the health center an integral part of the local community, leveraging the ability of the clinic to participate in community development as well as the clinical benefits gained by understanding local context. This is the basis for the very successful community health center program

started by Dr. Jack Geiger in the 1960s.[25] But there is no room in the PCMH for the local community voice; in fact, the PCMH retains the paternalistic ethos of medicine, although now the "father" of the medical home is the corporate bureaucracy. And how could the involvement of a clinic in health problems of the local community be incentivized, within a system of private insurance?

Is the Truth Irrelevant?

Medicine has struggled over the past several decades to move away from care based on expert opinion towards "evidence-based" practice. This is a project that faces multiple barriers and the transformation will probably last decades. Nonetheless, evidence-based medicine represents a laudable attempt to make our practice rational and beneficent. But the business school model's practices are not research-based. PCMH, P4P, and other interesting ideas have been introduced and implemented without thorough testing, just because to some people with power or influence they seemed like good ideas. We are (one hopes) smarter than that, in medicine; we want the proof of the smart idea first. It is striking that the business school (whose scientific basis has been severely questioned[26]) is now running the show.

On the labor front: as doctors become employees, they may well turn to unionization. Currently, only a small portion of doctors are unionized, but the call for a single national system has wide appeal for the union movement in the United States, and physicians may come to feel a common interest with unionized workers in other sectors.

When individual clinicians object that they are being forced to do things that make no clinical sense or are even bad for patients, they are told that these things are necessary for the purposes of the PCMH. When family doctors protested to the Academy about its partnership with Coca-Cola, we were told that this too was necessary. In short, we have arrived at the land described by Kafka, where lying has become a universal principle.

Alternatives to the Present System

The problems just listed, and others, have evoked widespread dissatisfaction and disillusionment among primary care providers. Some have responded by dropping out and creating models of care partially outside the system. Free clinics are estimated to host some 4 million visits yearly.[27] Other models are built around capitated payment systems: the purchaser –an individual, a union, an institution – pays a fixed amount to a clinic (or an individual doctor) to provide healthcare. Such models are not designed just to improve billing, but, in theory, to keep their patients healthy. Yet even at best, they do not point to an alternate system of healthcare.

Health Activism in the Era of the Affordable Care Act

The healthcare debate in 2009 provoked a broad movement against the corporate-friendly ACA; this movement supported a "Single Payer" plan" also known as "Medicare for All." It united groups of doctors (such as Physicians for a National Health Program or the National Physicians Alliance) with progressive nursing unions (National Nurses United, California) and community activists. After the bruising defeat of most progressive ideas in the final version of the ACA, this movement took on new life with the Occupy movement in groups like "Healthcare for the 99%" or "Doctors for the 99%." Around the country, healthcare workers participated in the protests both as citizens and as providers of medical care. In New York, doctors and nurses worked alongside street medics at the Zuccotti Park medical tent and protests were regularly staffed by street medics, some of whom suffered violence at the hands of the New York Police Department.

The focus of health activism has now moved from the national to the state level. Vermont has already passed a single-payer bill, to be implemented in 2017. A number of state legislatures are considering similar bills.

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These are promising movements and offer some potential for change, but within the larger constellation of political forces they are minor. Healthcare workers will need to be part of broader alliances. For instance, physicians and teachers are subject to the same market-driven forces of deprofessionalization and control. Both are in a position to understand how the degradation of education erodes the health of children, and how lack of health (e.g., poor quality school food) creates educational problems. Yet there do not appear to be many natural venues for cross-profession collaboration. A true Left party would be the best vehicle for making real change, but that seems a far off dream. Right now local work seems a more promising avenue. Can we find a place to meet and create progressive change?

Conclusion

Although the ACA has certain positive features, it leaves us with a very broken system that has now been formally handed over to the very medical industrial complex that created the problems in the first place. It is doubtful that making profit the heart of the system will either improve health or reduce costs; it is likely to make some people very rich.

The primary care infrastructure – which everyone agrees should be the foundation of a strong healthcare system – is in crisis. The MIC's proposed solution, the PCMH, shows little ability to resolve this crisis, even as it poses a fundamental challenge to the autonomy of physicians' work. Are we employees responding to the demands of our employers, or professionals whose call is to care for individuals? It is possible to be both

professionals and employees, but not without a continuing struggle for alignment of the missions that accompany the two roles – as teachers well know. In a healthcare system whose heart is profit, such an alignment seems unlikely in any near future.

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