

# Ownership

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**T**hank you all—I am truly honored. You know of course, that I'd be much more at home up here if I were talking about basic science. But this is a presidential address, so I have the responsibility to speak on broader topics, and especially to speak on your behalf in a meaningful fashion. So I will address a subject that affects surgeons, especially Trauma and Acute Care surgeons, viscerally but that we have been remarkably, uncharacteristically silent on.

Everyday, as we work passionately to care for the most desperately ill patients in the world we feel the influence of impersonal corporate medicine on our care and on our lives. The enormity and pervasive power wielded by corporate US medical interests has grown progressively for the last 40 years but has become infinitely more clear since the Obama administration established the Affordable Care Act (ACA)—an event which struck them a visceral blow in the purse. And if we are to continue to bring excellent care to the critically ill and injured without being constrained by corporate profit motives, we have to understand this system and how it relates to us. And eventually, we have to retake a seat at the head of the table where health care directions are established. Because the First Law of Business is: *if you're not at the table, you're on the menu...*

## US HEALTH CARE AFTER WORLD WAR II

Many of us here trained in the last quarter of the 20th Century. At that time physicians presided over an enormously productive, world renowned and socially cherished enterprise: the US Healthcare Industry. Doctors worked hard, they were very well paid, and they were universally respected. They had wealth, power, and prestige. When we spoke of “Doctors’ Hospital” of wherever it meant that the hospital was owned by the doctors who practiced there. Likewise, physicians who worked in outpatient settings owned “practices” made up of patients who had loyalty to them professionally and personally. For most physicians, healing was an enormous source of personal satisfaction. Physicians were popular heroic images, from “Ben Casey” and “Dr. Kildare” to “Hawkeye Pierce” (Fig. 1). To be sure, US Medicine in the post–World War II era had its excesses and its share of bad apples. But the trust and loyalty generated by devoted

personal care had tangible economic value and physicians could sell that accumulated goodwill or pass it to their physician children in the form of a medical practice when they retired. So it is not really surprising that young people were eager to become physicians. In fact, becoming “a doctor” was the single most reliable means by which a bright young individual coming from relatively humble background could both “make a difference” as well as “make it” financially, personally, and socially. Much of that cachet is now lost. Make no mistake, being a “doctor” is still desirable, but where going to medical school is still considered a good thing, it has far less economic potential than before and its prestige is challenged by business programs. So rather than passing their practices on, physicians are now burning out and quitting at record rates.<sup>1</sup> Many say that they would *never* advise their children to go into medicine.

So where are we now? What changed? The answer is remarkably straightforward: physicians no longer *own* Medicine. Ownership of the Business of Medicine has almost universally been taken over by corporate entities. How did that happen? Did we sell it out? Did we lose our way? Were we led astray? How did we go down without a fight; without even a whimper? And how did the once noble profession of Medicine and high callings like Trauma Surgery become just *jobs*? Those turning points are actually quite clear in retrospect though not widely recognized. But if we want to reverse the current trend we need to know how we lost *ownership* of our own intellectual capacities and physical talents to entities that know nothing about medicine and care far less about patients than profits. We also need to recognize our strengths and weaknesses as a profession and examine how our weaknesses are used to control us.

But knowledge is power. So my hope is that at the end of the day if we know a little more about that transition, we will see our mission going forward more clearly. Then maybe we can talk about how we as trauma and acute care surgeons can form a bulwark against the systematic theft of medical productivity from physicians by capital marketplace institutions. And then at last ...we can get *mad*. So I am not here just to moan: how we got here is important because understanding the past and present can help us create a better future.

## HOW DID CAPITAL MARKETS SEIZE OWNERSHIP OF US MEDICINE FROM PHYSICIANS?

### Where We Started

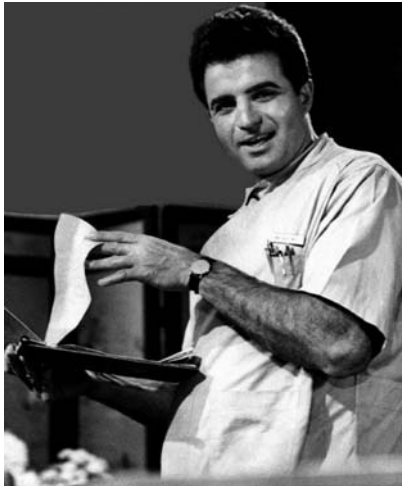
In 1970, health care made up perhaps 7% of the GDP.<sup>2</sup> Even so, it was still in many ways a cottage industry. We had (and have) no formal global leadership except trade organizations like the AMA. These acted (and still act) like medieval guilds, protecting primarily the *economic* position of US physicians, and doing it primarily by keeping others “out of

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**Figure 1.** Ben Casey was the archetype of a young surgeon in the 1960s. We all grew up aspiring to be like him: brilliant, independent, intense, idealistic and charismatic.

the marketplace.” Such emphasis on physician incomes may be self-serving in the short term, but has also alienated us from our patients, which can act to our disadvantage in the longer term. Many physicians I know understand this viscerally, and consider the AMA reactionary.

The market for health care also was (and is) especially unique in that health care is a basic need with no serious competition from other type of product. Moreover, outsiders cannot really judge the quality of the services provided.<sup>3</sup> So medicine was a “closed shop” that provided a service that was needed by everyone. But US physicians opposed any move toward universal health care. Beginning in the 1930s, US Medicine demonized universal health care as “socialized medicine.” US physicians similarly resisted the creation of Medicare in the 1960s, complaining that it amounted to “government intrusion into the practice of medicine.”<sup>4-6</sup> Employers similarly feared the growth of “health care systems,” thinking broad-based systems could impose monopolistic price increases. But considering their control over an industry with such enormous economic clout, physicians had little political influence. Hospitals and hospital corporations, however, evolved to use lobbying to control change and reap money and power.

Small wonder that US capital markets, and especially the financial products/insurance industry, simply saw the health care system as a lucrative “low-hanging fruit” and moved in. These entities were not licensed physicians, and so they lacked the statutory ability to practice medicine. But they had political savvy and clout and quickly found a way around that limitation. It was the landmark HMO act of 1973 that turned all those tables. Taking advantage of the fact that physicians often ignored their own business interests and were ‘free-thinkers’ who resisted conformity and organization, the capital markets enlisted the Nixon administration to gain control of health care. How? Here is a (minimally) abridged transcript of the Feb 17, 1971 ‘White House Tapes’ of the conversation between President Richard M. Nixon and Presidential Counsel John D. Ehrlichman (Fig. 2) that led to the HMO act.<sup>7</sup>

**Ehrlichman:** “On this ...health business ...”

**Nixon:** “Yeah.”

**Ehrlichman:** “... we have now narrowed down [VP Spiro Agnew’s] problems on ...whether we should include ...health maintenance organizations like Edgar Kaiser’s Permanente thing. [Agnew] just cannot see it [but] finally says, ‘Well, I don’t think they’ll work, but if the President thinks it’s a good idea, I’ll support him 100%.’”

**Nixon:** “Well, what’s the judgment?”

**Ehrlichman:** “Well, everybody else’s judgment very strongly is that we go with it.”

**Nixon:** “All right.”

**Ehrlichman:** “And [Agnew is] the one holdout that we have in the whole office.”

**Nixon:** “Say that I ...have doubts about it, but ... give me your judgment. You know I’m not too keen on any of these damn medical programs.” ...

**Ehrlichman:** “This... this is a... private enterprise one.”

**Nixon:** “Well, that appeals to me.”

**Ehrlichman:** “Edgar Kaiser is running his Permanente deal for profit. And the reason that he can do it - I had [him] come in and talk to me about this and I went into it in some depth - [is that] all the incentives are toward less medical care, because ...the less care they give ‘em, the more money they make.”

**Nixon:** “Fine.”

**Ehrlichman:** “... and the incentives run the right way.”

**Nixon:** “Not bad.”



**Figure 2.** John D. Ehrlichman was president Nixon’s main domestic affairs adviser and a key early supporter of corporate medicine. He later went to prison for his role in the Watergate burglary.

Just to reflect for a moment, that was the exact moment in time that we got taken to the cleaners... The very next day (February 18, 1971), Nixon (Fig. 3) went on the air and said: “I am proposing today a new national health strategy. The purpose of that program is simply this: I want America to have the finest health care in the world and I want every American to be able to have that care when he needs it.”<sup>8</sup>

Nothing he said there was true: it was a smokescreen, meant only to convince voters that they would be getting more



**Figure 3.** Richard M. Nixon's use of lies to achieve political ends gained him the nickname "Tricky Dicky." Nixon readily endorsed the concept of a "free-enterprise" takeover of medicine where medical "consumers" got less care for their money and the difference became corporate profit. He promised corporate medicine would produce "the finest health care in the world" though he knew their specific business plan was to decrease care.

when they were really going to be getting less. We see similar less-is-more euphemisms (eg, "patient-centered medicine") in broad use today. But in reality, the HMO Act (1973 S.14) did three specific things that gave "corporate health care" a lethal competitive advantage over physician-owned and controlled medicine:

- (a) it gave direct government subsidies to HMOs,
- (b) it allowed insurance executives to challenge the medical judgment of licensed physicians.
- (c) it mandated that all businesses with >25 employees offer an HMO option.

In the 1980s, Congress went still further, allowing states to use Medicaid Section 1115 waivers (those were supposed to foster pilot health care programs for the poor) to push Medicaid recipients into commercial managed care. HHS proposed that those waivers provided states "flexibility to develop innovative solutions." But in fact, these new waivers countermanded existing federal Medicaid laws by allowing limits on treatment and on physician choice.<sup>9</sup>

### How Corporate Health Care Evolved

Using these competitive advantages, capital markets progressively (and aggressively) annexed the health care industry. And in the course of that process they accumulated a staggering amount of wealth and power. So if Nixon's idea was to lower health care costs he failed miserably; because in the hands of Corporate Health care, the real cost of medicine has almost tripled to the incredible 17.5% of GDP we see today. Yes, we do some things better, but I think few would argue health care improvements justify a 250% increase in real cost. Is this simply because greedy doctors are charging more and more? Well, surely there are greedy doctors. But careful studies show that real physician incomes have shrunk substantially.<sup>10</sup> So then,

where does the money go? Well, a big piece of the budget no longer goes into medical care at all: it funds a bloated health care administrative structure that actually aims to diminish *both* health care delivery *and* physician incomes in order to "enhance shareholder value," that is, to increase profits and thus increase share prices. So how did our practices become their equity?

To understand that, it is useful to examine the relationship between capital markets and political power in post-World War II America. In his farewell address on January 17, 1961, President Dwight Eisenhower (Fig. 4) wisely said:

"Until [WWII] the United States had no armaments industry. American makers of plowshares could, with time and as required, make swords as well. But now we ...annually spend [more] on military security than the net income of all United States corporations. This conjunction of an immense military establishment and a large arms industry is new in the American experience." To describe that conjunction of industrial power and political influence Ike coined the term "the Military Industrial Complex." And in the 50 years following Ike's description, American tax-payers paid the Military Industrial Complex for tanks that rusted in Germany, napalm that fell in Vietnam and JDAMs that fell in the Middle East. We paid for our military power with treasures that could have built us into a Camelot.

The Military Industrial Complex persisted through the end of the Cold War 50 years later, supported by wartime foreign policies driven by industries that benefitted from them, and became so rich they could perpetuate their interests in the halls of government. But with changes in geopolitics, the overwhelming power of the military-industrial complex was succeeded in economic power first by the fossil fuel industry and now by a Health Care Industry that has evolved into a Medical Industrial Complex (MIC). This new MIC has grown in power and influence to a point where (as Eisenhower said of the Military-Industrial complex) "The total influence - economic, political, even spiritual - is felt in every city, every state house, every office of the Federal government. ...[and] we must not fail to comprehend its grave implications."



**Figure 4.** President Dwight D. Eisenhower saw the evolution of corporate influence in government and recognized how a confluence of economic and political power could divert national interests towards corporate goals.



## Where We Are

I would argue that for about 15 years we have had just such a national MIC where the foxes are firmly in charge of the medical henhouse and the health care industry now responds almost exclusively to corporate profit motivations. So when the ACA placed a statutory limit on the earnings of health care industry by imposing a “mean loss ratio” (MLR) of 80–85%<sup>11</sup> it effectively capped MIC profits at 15–20% in excess of costs. Although that seems a quite reasonable return on expenditures, it also meant that corporate earnings (and thus stock prices) could only increase in two ways: 1) increasing the *cost* of health care or (2) *repeal* the ACA. So we saw the deep pockets of the MIC go to work to do *both*.

Cleverly rebranding and demonizing the ACA as “Obamacare,” we saw near limitless funds—\$100 million from United Health Care and Cigna alone<sup>12</sup>—go through lobbying groups like the “U.S. Chamber of Commerce” in efforts to destroy it. Still more came from far right-wing deep pockets like the Koch brothers and went through PACs with euphemistic names like “Citizens for a Sound Economy” or “FreedomWorks.” Huge amounts of money were funneled through corpulent right-wing operatives like Dick Arme. And didn't we all stare in wonder when large numbers of heretofore neutral senior citizens were suddenly given free bus-rides and bologna sandwiches to go to Washington supporting venomous, manufactured senior citizen opposition to the ACA when, after all, the ACA has little real effect on Medicare coverage? Who paid for those buses? Although the ‘Citizens United’ Supreme Court decision makes it hard to be totally sure, it is a safe bet that much of the support for candidates pledged to ACA repeal in the last election cycle came from the same quarters. We can now expect these forces to become even more entrenched. And like the Military Industrial Complex before them, they will use their political power to change laws and social policy simply to enhance their profitability.

## HOW HAS CORPORATE MEDICINE CHANGED SURGEONS?

Changes in medical care over the last 20 years have had enormous effects on physician thought and behavior. Physicians have been forced to change as people. Medicine was once a bastion for humanism. Surgery was a bastion for charismatic individualism. Much of this is gone: I would argue, suppressed. My generation grew up in a medical environment filled with friendship, camaraderie, professional courtesy or competition, success or failures, love affairs that erupted in operating rooms and call rooms and then flourished or died. We were abused by bad people and took heart from wonderful people. We worked our way through it. It was hard but never boring and we gained enormous experience. Could it have been better? Sure, maybe, but no one I know looks back on those times with anything but affection. Now the enormous humanism of those experiences has been replaced by bland corporate conformity and a profound lack of personality. All of these have been institutionalized in the name of “professionalism,” codified under the mantra of “compliance” and enforced by the corporate cudgel of “H.R.”

How does corporate medicine benefit by controlling physician behavior and even flattening physician affect? We are all in favor of professionalism, though we may each define it a little

differently, but shouldn't we also be in favor of excellence, honesty, charisma and even (yes) love? Yet at this point essentially all nonprofessional relationships are suppressed in corporate medical culture. Why should that be? Generally, we accept that this is a corporate method of managing potential legal liability. But we are still all aware of hospital romances. So it seems at least as likely that corporate suppression of interpersonal relationships is meant to deter feelings of solidarity among physicians except in ways that support productivity (as might be seen in Japanese corporate baseball team outings) and so prevent professional organization.

## Seeking Excellence Versus Quality

Historically, surgeons have always tried to deliver the best possible care. The advent of a corporate ethos however, challenges that ethos with requirements for productivity and profit. This is currently a major source of harmful internal conflict in surgeons. What exactly *is* a “best practices, managed care cholecystectomy product,” anyway? How should one measure excellence in surgery, anyway? Corporate Medicine uses “quality officers” who are typically generalists. They seldom practice in the fields they oversee since that would be very expensive. They create “process variables” based on related evidence and seek to meet related goals. “Quality assurance” is then assessed as compliance with those “best practices.” But it is important to understand that quality assurance neither *is* quality nor assures it. It is a process assessment method that can potentially yield a foundation for care, but it is hardly a cathedral ceiling.

We are also asked to use corporate methods like “root-cause analysis” to assess our work. But these do not even get close to the truth of remediable surgical errors. These processes often describe all the holes in the Swiss cheese that lined up except for the one real preventable error that really could have changed the outcome, like operating at night or over the weekend. But as Colbert would say they show “truthiness,” so they do not need to get at deeper truths. So too often these processes become tools for guilt-management rather than for self-improvement. Real quality in surgery requires a far more detailed understanding than a fishbone diagram can ever convey. Complex decisions made in the ‘haze of battle’ are understood (if at all) by physicians with equivalent training—never by task-driven “physician managers” or quality officers without relevant specialty-specific experience. Real excellence is created through honesty and transparency. It also requires recognizing the inevitability of errors when diagnosis and treatment have to proceed at the same time. In ...the world of Acute Care Surgery, “errors” are often simply successive best guesses meant to be followed by course corrections as data accumulates. So “quality assurance” is no replacement for “excellence” and if we accept *ownership* of excellence, our care will surpass that assured by “QA.”

## Seeking Integrity and Honestly Versus Insuring Compliance

We all expect to work in an environment where physicians are honest and act with integrity, including in their economic practices. The same practice guidelines are certainly desirable in health care organizations. In my practice lifetime, however, I have seen medical billing go from a routine, boring task to a form of economic warfare where money is hidden in a shell

game of mutable diagnosis codes and reporting requirements for as long as possible. The winners here profit on the immense investment “float” of a near trillion-dollar industry and losers are quickly driven into extinction. So it is that billers and payers have each thrown their best and brightest talent into an ever-escalating war of regulation and denial versus upcoding and unbundling. Thus, in the corporate health care battlefield, important concerns have arisen with respect to integrity in billing, and the battlefield is controlled by a set of rules called “compliance”

But although it is corporate medicine that now bills and collects, it is the physicians who must follow the regulations and corporations insist that surgeons are trained in billing compliance. Why should that be? There is really no problem with surgeons billing fairly for their services. After all, the physicians who are really most aggressively concerned about income have long since fled to “cash money” (cosmetic surgery, sports medicine) and “closed shop” (neurosurgery, spine) disciplines for the last 20 years. Trauma surgeons, acute care surgeons, and intensivists are really not known for this kind of issues. Moreover, typically the corporate medical systems we work in do our billing for us, typically directing us to the “best codes” for specific services. Why then are we required to take yearly billing compliance courses and sign attestations that we have fully read and fully understand the material, complete with its references to the entire Code of Federal Regulations? The answer, I fear, is that corporations want to bill as high as they can but then to indemnify themselves against billing malfeasance actions by interposing a presumption of physician misconduct between themselves and the payers. So in this new corporate world, we need to be honest (as we have always been). But we also need to be wary that we are being set up as “patsies” to “take the fall” for corporations if we don’t police our billing and report transgressions. Remember that we are protected when we do so. But if we accept *ownership* of integrity then compliance is a secondary concern.

### The “Doctor-Patient Relationship”

Over the last 20 years, corporate health care has slowly but dramatically changed the tenor of relationships that have historically existed between physicians and patients. Now a major part of Medical School curricula that often seems to have eclipsed anatomy and physiology in importance, the “structuring” of relationships between physicians and patients has in fact stripped much of the joy from our practices. Any kind of friendship between a physician and a patient is viewed with the utmost suspicion. Why is that? From the standpoint of a “business plan” the answer is pretty clear: corporate health care wants to assume credit for good outcomes from care and so gain the gratitude of patients. In fact, that seems a beneficial goal. But it is also normal for goodwill to accrue to the individuals who help others in the course of care. Surgeons help people in a very tangible way and therefore gain their gratitude. And the reinforcement gained from that gratitude is typically one of the primary reasons why surgeons go into their difficult and demanding profession. It seems inhuman and unnatural to me to interfere with such primary human transactions, and I believe that the loss of reinforcement and gratification from practice that attends these changes is a primary cause of accelerated physician “burnout” within Surgery and in Medicine in general. Yet current codes of conduct frown on physicians accepting the smallest token of patient

gratitude. Conversely of course, it is considered a corporate “best practice” for hospitals to solicit major gifts towards capital campaigns immediately at discharge. Thus, corporate health care wants to arrogate patient gratitude to itself, assuming that this will result in increased “product loyalty” and eventually in increased shareholder value (ie, profit). Anger over bad outcomes of course, may appropriately be directed at individual practitioners. We need to take back *ownership* of the gratitude of our patients and always try to be worthy of it.

### Surgical Leadership Versus “Proceduralism”

All physician leadership weakens the competitive position of corporate medicine. In a recent training film that I was required to watch about “scripted surgical timeouts,” the surgeon was referred to as the “proceduralist” where the OR staff were called the “care team” and the circulating nurse was termed the “patient advocate.” This made me stop and think: don’t surgeons care for patients? In fact, isn’t the surgeon the “team leader?” I believe that the hardly subliminal message here is that surgeons should limit their interactions with patients to the technical accomplishment of an operation. We must actively reject this approach. OR support personnel are vitally important, but it is uniquely the surgeon’s role to conduct and orchestrate everything that happens in the OR. We must defend this moral high ground and resist all attempts by the health care industry to steal it in subtle and pervasive ways like this. The function of the OR team is to support *our* delivery of health care. It is *not* the other way around. It is time to come to a “HARD STOP” here and insist upon the respect that is due to us in recognition of the level of responsibility that we have trained for and chosen to accept. And we as surgeons are ethically and legally responsible for the totality of care in the OR anyway under the *respondeat superior* doctrine.<sup>13</sup> Conversely, hospitals are historically exempt under the “Schloendorff doctrine” which regards surgeons in the OR, even as hospital employees, as independent contractors because of the skill they exercise and the lack of control hospitals exert over their work.<sup>14</sup>

But where there is governance by committee there can be no *ownership*. I think most of us in this room see surgeons as the ultimate patient advocates. After all, we stand between our patients and disease or death. Our job is often to get them what they need, not only from us but from the nursing station, from consultants, from Central Supply and from the whole health care system. Corporate health care specifically seeks to limit the scope of our relationship with patients by taking this kind of global responsibility away from us. I would argue that we need to maintain our personal bond to our patients because it improves care and outcome. The term “team approach” has become a euphemism for disenfranchising physicians and a “team player” has become just another term for someone willing to take orders. Physicians may be replaced by “clinicians,” “practitioners,” “health care givers,” “therapists,” but none of these are *surgeons*. And although they may all serve valuable roles in the healing of patients and may cost less individually, they deliver far less care. Ultimately, “team approaches” really rely on *disintegrated* care delivered by persons who lack the overview needed to achieve real clinical excellence in complex disease processes. This often degrades clinical outcomes. We need to demand and hold *ownership* of the decision making processes that affect our patients.

This is a demanding path that requires far more time and effort than proceduralism. But with power comes responsibility, and *we should not expect to have one without the other.*

## HAS CORPORATE HEALTH CARE CHANGED TRAUMA/INTENSIVE CARE?

Business models all derive from a basic focus on acquiring resources cheaply and selling them at a profit. In the hospital setting, the resources being bought and sold are typically (our) medical services. But health care systems don't understand physiology or immunology: they understand productivity. So corporate health care systems attempt to do in intensive care units (ICUs) what they do best, and that is to create assembly line models of care. But expert critical care requires coordinated use of multiple already complex knowledge bases and rapid pattern recognition. This constitutes the "fuzzy logic" that is required to recognize where new data does not readily "fit the mold." This is something expert intensivists who like to "think outside the box" do incredibly well. Algorithms and pathway-based care do it notoriously poorly. No—airlines don't fly based on "fuzzy logic."

### The Fragmentation of ICU Care

Historically, assembly lines are successful when they can replace expensive, cross-trained craftsmen with low-price workers who can be trained to perform a single task many times. This works well when small, independent pieces of a supply-chain can be subdivided and then reassembled. I would argue that some assembly-line approaches in medicine can be a very good thing. We can certainly use such methods effectively for immunization and preventive care programs. Postoperative care in some kinds of elective surgeries lends itself to protocols. But protocols fail trauma patients and patients with multiple organ failure syndromes in very predictable ways. So *fragmentation* of surgical critical care results in a loss of coordination between the care of linked physiologic processes. Thus, it degrades global care and overall outcomes. I think we have all seen events in ICUs where pieces of our global care, of our patient *ownership* have been parsed out to allied health care professionals. We have all seen this and in fact, we become complicit in that degradation when we allow laziness to creep into our professional lives. Let us look at some concrete examples.

### The Fragmentation of Respiratory Care

How often have we all seen or heard the morning rounds scenario where a ventilator-dependent patient has taken a step backward overnight, and that the respiratory therapist has moved the patient from partial to complete ventilator support? Then when we ask the overnight resident why the change was needed, it turns out the change was made with no physician interaction. And if (as is commonly the case) the diminished respiratory function was a manifestation of new onset sepsis, that might have been identified 6 hours earlier with improved outcomes. We don't expect most respiratory therapists to have that level of insight. But we do hope to see it in our residents. Unfortunately, when I tell residents I expect more patient *ownership* from them, they tend to stare at me blankly. But that's better than

the open hostility of RTs who think I am usurping their prerogatives as to how to "run the ventilator."

### The Fragmentation of Nutritional Care

Let's look at another vitally important piece of critical care: nutrition. Do we maintain *ownership* here? I make it my business to review all nutrition orders daily. Commonly, these orders are written by nutritional therapists with little input from physicians except to order enteral versus parenteral feeds. One result is all-too-frequent use of "disease-specific" nutritional supplements. These rarely have proven benefit and always cost more than standard formulas, but they may have significant complications. Nutritionists are also trained to recognize caloric deficits but seldom notice the metabolic effects of overfeeding. So without intensivist oversight, it is common to see ICU patients develop hyperglycemia, azotemia, hyponatremia, osmotic diarrhea, and fatty livers. These expensive and morbid problems often disappear when the patients go on standard iso-osmolar feedings based on predicted lean body mass rather than on wet weight. Last, nutritionists know how to calculate requirements for TPN but do not know which patients can tolerate enteral feedings or how to safely obtain enteral access. Without oversight and *ownership* this leads to an inappropriate emphasis on use of TPN which is out of step with current scientific understanding and leads to predictable and avoidable immune and metabolic complications. Whenever we unbundle our global care by ordering "diet per the nutrition service," we accept these diminished outcomes.

### The Fragmentation of General Care

Another common instance of loss of surgical *ownership* is allowing a speech pathologist to determine when patients can take oral diets or when a patient with a tracheostomy can use a speech prosthesis. As intensivists we should be confident of our own abilities to handle that. But there are nonetheless hospital generated protocols in place that *require* nurses to request "speech and swallow evaluations" anytime a patient is started on a diet. Typically, I simply take applesauce and a teaspoon to the bedside and document the patient's ability to swallow on the chart. Yet I have often been challenged with "nursing concern" for potential liability due to aspiration when I do this. But I don't accept that this expensive approach to care really reflects a fear of litigation. Physical examination is very reliable and cheap. Also, personally initiating postoperative feedings is one of the fundamental ways that I forge a human bond with my patients. The first bite of food after a long illness is memorable and helps to cement my *ownership* of the patient's care. Similarly, when a tracheostomy patient says "hi" for the first time, it reconnects them to the real world and they remember it. Being with them at this critical juncture helps me to form a bond with the patient.

### The Monetary Costs of Fragmentation

So why aren't these services simply a routine part of surgical (and nursing) care anymore? Are we lazy and demanding that others perform these services? I have not heard many outcries for more speech pathologists. I have already proposed that industrial health care entities do not really want us to bond with patients. But there are also financial drivers. It is not widely



known that under some circumstances services like speech pathology, swallowing studies, placement of percutaneous catheters (“PICC lines”), and sleep apnea studies are billable outside of global DRGs as Medicare Part B services.<sup>15–18</sup> And when such ancillary services are not performed by physician-led services, the hospital system may bill the services and capture the income stream from them directly. This could explain the proliferation of mandates for automated (ie, nurse-driven) consultation of these services. Moreover, even when nutrition and speech and swallow services are included in DRGs, their use can directly increase DRG reimbursement rates because of the associated increase in “case mix index” (“CMI”). This should be totally legitimate where patients merit the service in the opinion of the responsible physician. But where college-age distance runners get appendicitis and automatically get a nurse-driven nutrition consults because they are briefly NPO or have a body mass index less than 20, something is amiss. And when the hospital coder asks me to confirm the nutritionist’s diagnosis of “moderate malnutrition,” I have to become *uncomfortable*. It is sobering to peruse “speech and swallow study” reports and examine the “swallowing G-Code” billing data that are generated in them. Occasionally such consultations are needed and useful. But abdication of *ownership* of this simple and personal aspect of patient care can also drive up costs without improving care. Moreover, “greedy physicians” are often blamed for those increased cost of medical care even though we may be required by hospital protocols to order the services.

### The Fragmentation of Compassion

No corporate medical enterprise will ever truly understand the human side of ICU care. No matter what attempts health care industries make to portray a public face of compassion (they spend enormous energy at creating this impression) at their core, they still interact with patients as customers who are purchasing a product - not human beings facing critical illness and potentially death. This is the core mission and calling of physicians. It is why Medicine is a “profession” and not a “trade.” Patients need help and they need to feel helped. Assigning economic values to those human responses is impossible. No actuary can calculate the complex feelings of a patient who is alive with a colostomy instead of dead from diverticulitis. Hiring Mother Theresa as a corporate spokesperson will not help. And it is impossible to place a monetary value on the bonds we forge talking to the families of dying trauma patients at 4:00 am. These events reflect our humanity, our individual styles and our personal charisma as practitioners. It is a part of our calling to relieve suffering and it cannot be co-opted by the delivery system. Maybe that’s why patients’ showing gratitude to physicians is so actively discouraged. So if a patient likes you, thinks you saved their life and wants to send you a bottle of wine should you really redirect the patient to the hospital development office? I think that is an insult to the patient and to the physician. And I confess that when I have spent a year or two putting a patient together and they graduate, sometimes we will hug. Should I be dragged off by the heels to HR? Well, I will take my chances. But for the young in this audience, that is one of the best feelings in the world, and corporate health care wants to steal it from you. The MIC wants the patient *you* saved to be grateful to *them*.

### The Fragmentation of ICU Outcomes

ICU care is inherently complex and highly granular. Health care systems are not created so as to understand either the science or the human side of critical illness. Early mortalities might seem cost-effective. But the “value” of ICU care to society also varies depending on whether the patient goes back to work, to their home, to a long-term acute care facility, to rehabilitation or to a hospice. So corporate health care systems must engage consultants to measure “quality” in these highly technical areas. Such consultants are typically familiar with circuit diagrams, decision flowcharts and root-cause analyses. But creating measurable change in “hard” ICU outcomes is very difficult. So to produce “measurable results” these consultants assess success and failure using “process” metrics like “adherence to a ventilator bundle” rather than with “hard” global outcomes like “ventilator-free days alive” where improvements are much harder to come by.

As to the human experience of critical care, I have seen consultants trying to measure “family satisfaction” with questionnaires after a cardiac arrest as if it were an online shopping experience. But these consultants have never had to decide who to send from the ICU to the floor when there was a bed shortage. We have to do that. But then our complex efforts to compare clinical apples and oranges to do the right thing are routinely second-guessed by MD-MPHs who have never been at a trauma resuscitation, and RN-MBA’s who beat their bedpans into clipboards 20 years ago. It would be funny if it were not tragic.

### HOW CAN WE REASSERT OWNERSHIP?

I firmly believe that the disciplines of trauma, acute care surgery and surgical critical care are in a unique leadership position where we can start to recapture *ownership* of health care from the MIC. If so, we can help reverse the slide of surgery from a respected, even revered profession into a second-class job working for corporations that value surgeons as “production units” rather than as thinkers and leaders. We have a unique relationship with our patients and exert broad authority over their care because *no one else can do it*. So we have a one-of-a-kind opportunity to exert our leadership if we are careful to do it in ways that our patients support and that yield excellent and (yes) cost-efficient outcomes.

### Distinguishing Health Care From Health Care Delivery

The initial step in exerting global authority should be to act like scientists and look at the mechanisms that define our situation. So first, let us ask what the health care industry has really taken control of. In reality, they have taken control of the means of health care *delivery*. For the foreseeable future, licensed, trained, and board-certified physicians are, and should continue to be, the only entities capable (and more important, legally empowered) to use their intellect for the *creation* of health care. The health care industry would love to use widening pools of cost-saving “providers” and even computers to deliver health care. But legally, at some point, no matter how capable mid-levels or allied health care providers may be, licensed MDs still have to “sign off” on their care. There are no viable alternatives on the horizon. So at least as to caring for patients, we are still in

that drivers' seat. So if capital markets want to regard us as a commodity, then so be it. But let us act more like the oil-producing nations have vis-à-vis the oil industry. Our position should be that *they may own the tankers, but we own the oil...*

### Asserting Global Ownership of Patient Care

As health care *producers*, we are the only game in town. So how best should we exert that power to regain authority and exert our focus on excellence? The immediate question that arises is whether we should unionize and/or use strikes as tools to assert ourselves. Historically, this has been seen as creating both legal and ethical concerns since "medical care ranks along with law and order as a central tenet of our society."<sup>19</sup> But although once unimaginable in the US, strikes are now beginning to be considered.<sup>20-22</sup> The legal considerations are probably changing as physicians have evolved from having 'independent contractor' status towards being employees. Moreover, physicians who work in the public and private sectors have long been held to be different under law.<sup>23</sup>

Adding to our power though, the acute care surgery discipline occupies a particularly time-sensitive crossroad where our work involves disease processes where treatment cannot be put off. So such a strike would be a target for governmental intervention. This could happen of course, with any strike affecting "basic services." But recall that the Medical Industrial Complex has purchased an unheralded degree of influence on the current administration in Washington. So action under Taft-Hartley<sup>24</sup> would seem assured. But health care strikes are actually not, strictly speaking, illegal. Rather, they simply require 10-day advance notice.<sup>25</sup> So with that in mind, it is clear we could still bring the system to its knees rapidly.

But ethics and legalities aside, I would argue we should *not* strike. First, we do not really need to. Second, there certainly would be harm to patients, although I would argue that the short-term harm would be more than outweighed by the long-term good of physicians taking the control of health care out of the hands of big business. But by far most important, we would lose our patients' good will, and that good will is our greatest asset. By striking, we would leave ourselves open to accusations of greed and insensitivity to our patients' needs that would be immediately promulgated by corporate health care, when that is exactly what corporate health care is guilty of and is exactly the brush that we should be painting *them* with. And last, we have other robust possibilities available to effect change that will universally be seen as "positive" and that will enhance our ability to maintain *ownership* of medicine.

Our first action is easy. We should constantly remind our patients of who we are and of our personal relationship to them and their wellness. Winning the "hearts and minds" of our patients must be a central tenet of reestablishing our dominance. Sick and injured persons and their families are voters to politicians and they are customers to the health care industry. But they are *patients* to us and that is a very special relationship both historically and legally. So in effect, as we let our patients know "Who's your Doctor?" we are letting the corporate health care industry know "*Who's your Daddy?*"

Second, very few medical services can be billed without a physician's signature on something, somewhere. Thus, as soon as we stop thoughtlessly clicking and signing every note put

under our nose we can exert a powerful control on institutional cash flow. Here the pen can indeed become mightier than the sword (and the "suit"). We need to wield our pens wisely since this will surely be labeled "noncompliance." Of course, in the court of public opinion, non-compliance is not a big deal, especially if we are still taking loving care of our patients and they know who we are by name. But more importantly, "corporate compliance" can also be our ally if we use it wisely and allow compliance to become a two-edged sword. Let us allow the thousands of (unpaid) hours of compliance training that health care organizations have saddled us with to insulate themselves from billing and coding liability to be harnessed to re-establish our central role in health care. And we can do it with ease because we alone understand *both* the codes *and* the disease processes that they represent...

So to control cash flow while insulating ourselves from actions based on noncompliance, we need only recall our "Human Resources" training. Remember those amorphous expressions of politically correct discontent that can get aimed at us if we give a medical student a grade less than "High Honors"? Using HR speak is actually fairly easy. We simply have to apply our compliance training and document that we feel "uncomfortable" or "concerned" about signing documents that may be incorrect or noncompliant. For example, we should not sign hospital discharge summaries where residents or midlevels have cut-and-pasted physical examinations (of course, they cut and paste them all). Let your administration know by email (and send a cc to a safe server) that you are *concerned* or *uncomfortable* in signing this document because it might create a compliance violation. Similarly, when we are asked to write assessments on the chart that allow "up-coding" patients (eg, from "CHF" to "diastolic CHF"), we should be very cautious and precise. If there is no evidence (eg, a cardiac echo), we can reasonably decline on that basis. If then pressured, the correct response would be to say that you are *uncomfortable* about being pressured to change a diagnosis that you are uncertain about. Your email should be copied to an institutional compliance officer with a copy sent to your personal server for safekeeping.

A third potential means of maintaining physician quality control over care is simply to report safety issues regarding protocol-based nonphysician care. It should be a routine that when patients are treated by allied health care professionals without physician oversight and it causes *any* problem (like hypertonic feedings causing osmotic diarrhea or central line associated bloodstream infections originating from a PICC placed by a hospital based technician) we should routinely write "safety reports." These are important quality controls that we have left to others for much too long. All such actions are protected by law as long as they are truthful and not malicious. But we do not have to look far to find safety problems because we know what they are. The MIC does not, they only want to be able to say that to the best of their knowledge they don't exist. We need only bring them into the light.

A fourth potential source of power is recapturing postoperative services that are an appropriate part of our usual scope of services. Rather than happily abandoning postoperative care as an annoyance, we need to insist that postoperative care needs to be performed under surgical supervision. This is a safety



issue. Remember that the industry is not generously doing our postoperative care for us: it is marginalizing us as proceduralists while simultaneously improving “case mix index” by showing a need for ancillary services. But we cannot be required to order these services where they create “safety concerns.” And in cases where medical authority for routine use of ancillary services is created by hospital committees and “signed off on” by physicians there, medical staff action at the hospital committee level must be aimed at withdrawing such authorization.

Not only can we provide these services better, but if we take control of ancillary care givers, it can be a source of compensation to us rather than the hospital. In some institutions transplant surgery has their own nutritionists and ENT hires their own speech pathologists. Such relationships enhance global ownership and lead to better integration of care. Hospitals may resist our taking control of these services and their associated income streams. But again, we do not have to order them if they are not warranted or if the services are inferior when delivered without direct physician oversight. This sounds like more work for us but we already do most of this work this anyway. So taking back *ownership* can create physician power and decrease overall cost of health care.

The fifth and last potential source of power that is physician assertion of ownership and control of medicine at the political level. This begins at the level of hospital committees. Acute care surgeons must be active and aggressive in hospital governance. Medical corporations currently steer these committees as a means to create “medical staff actions” that promote corporate ends. Surgeons on these committees need to look at proposed committee actions carefully, making sure they don’t disenfranchise us. Political action is also necessary at the level of the corporate boardroom. To do this, some of the younger surgeons in the audience today must take a serious interest in politics, economics and corporate governance. My suggestion if you are really interested would be to invest a year or two in getting an MBA, an MPH or a JD. If I were younger that is exactly what I would do, just to get a seat at the table. I’m sure that there are other ways to get into positions of power in the health care industry that younger people in the audience with different skill sets can find. But I will repeat the First Law of Business ... if you’re not at the table, *you’re on the menu!*

### IN CLOSING...

In summary, over the last 40 years, a Medical Industrial Complex has used political power and patronage to take ownership of US Healthcare away from physicians. This complex is so large and powerful right now that it elects its own presidents and writes its own laws. But we still own ourselves and we are uniquely the creators and producers of all health care. So we do have power and there are methods available to retrieve control of medicine, making it work more to the benefit of patients, and if need be, fighting against corporate control of Medicine by “hitting them where they live.”

We do not need to be commoditized medical robots (Fig. 5) that provide managed-care small-bowel obstruction products. We only need to be as tough in business as our corporate health care would-be masters are and to put our minds together like they do. We are smarter and we know medicine



**Figure 5.** WPA poster from the play “Rossum’s Universal Robots” by Karel Capek (1921) Capek invented the word “Robot,” deriving it from the Russian word “robot,” which means “work.” Created to perform menial tasks, the robots eventually took over the earth and destroyed the human race.

better than “the Industry” does and we have the goodwill and gratitude of patients. We own our knowledge bases and we produce all health care. If we allow those facts to be diminished, the “suits” will gloat as they turn our productivity into their “shareholder value” and corporate seven-figure stock options.

So then, why is mobilizing physicians so like herding cats? We all value our independence as a strength, but our independence is also a weakness that corporate medicine uses against us. We need to be interdependent, and we don’t have much time to start doing it. The “end of times” is in sight as medical schools have become complicit in creating a new cadre of physicians who accept the corporate vision of what health care should be. Our students already are taught more about “The Doctor-Patient Relationship” than they are about respiratory physiology. That is, of course the province of respiratory therapists—or isn’t it? We need to teach and practice global *ownership* 24 hours a day. We also need to be unique individuals who serve individual patients with ethics and humanity. And when some fail in that we need to police our own ranks effectively to avoid giving that cudgel to the health care system.

### How Do We Initiate Change for the Better?

I have made some suggestions, and there are many here who surely will have other ideas that may be even better. But first to mobilize our ranks we have all got to get mad. Then we can create work actions that bring public support and harness the public’s *inherent distrust of corporations*. In the 1976 film Network, the prescient screenwriter Paddy Chayefsky predicted the corporate takeover of America’s noblest, most elite institutions and the subversion of their quality and integrity toward profit. So I would like to paraphrase what the actor Peter Finch

said, who literally died creating the Academy Award-winning role of nightly news anchor Howard Beale<sup>26</sup>;

"I'm a SURGEON, God damn it! My life has VALUE! So I want you to get up now. I want all of you to get up out of your chairs. I want you to get up right now and go to the window. Open it, and stick your head out, and yell, 'I'M AS MAD AS HELL, AND I'M NOT GOING TO TAKE THIS ANYMORE!'"

...and brothers and sisters, it is time for us to start yelling...

#### DISCLOSURE

The author declares no conflict of interest.

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