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Editorial

What happened to "Patient first" and "Do no harm" medical principles?

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Health care today is losing its primary focus on patients as the physicians' motivation is declining, together with emerging new clinical practice guidelines that tend to estrange the patients and caregivers. There is an even greater need to serve a third party (e.g., payments based on the relative value unit [RVU] system), which makes practicing medicine more like a business.

RVUs were introduced in 1992 as a part of the system that Medicare uses to decide how much it will reimburse physicians for each of the 9000-plus services and procedures under its physician fee schedule and which are assigned current procedural terminology code numbers. The dollar amount for each service is determined by physician's work, practice expenses, and malpractice insurance. The sum of three components is multiplied by a dollar amount known as the conversion factor to calculate reimbursement amount. RVUs are a useful way of comparing how well payers reimburse for the same service or procedure. In addition, RVUs can be used as a tool to help multiphysician practices determine how much to pay their physicians.[2] By applying a straightforward normalization process, developed by the clinical practice management plan, organizations can effectively use RVUs as a comparative tool not only for measuring productivity but also for assessing the effectiveness of rate negotiations and tracking volume trends in clinical services.[8] Health-care systems have measured faculty clinical activity using RVUs for several decades, and active clinicians may see their compensation vary considerably according to the volume of RVUs that they generate. Faculty academic productivity can be measured and financially rewarded according to an objective academic bonus system, which functions as an "academic relative value unit."[10]

There is less and less incentive for quality custom care, as doctors have little voice left in this system. Health-care providers identified nine organizational factors they believe influenced their motivation: compensation, working environment, managerial leadership, organizational policies, coworkers, recognition, job security, job identity, and opportunities for promotion. Effective management is an important enabler of quality from perspective of providers, managers, policy-makers, and payers, because without good management, good ideas for quality improvement would be useless.[11]

The majority of updates, conventions, and meetings, particularly in neurosurgery, are no longer about how to improve the quality of care. Rather, they largely address new regulations, protocols, surveys, and how to maximize billing for surgical procedures, some of which are unnecessary, irrespective of outcomes. The particular

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issue of unnecessary surgical procedures has been briefly addressed,[4] and was demonstrated in neurosurgery as well.[13] It has been observed that communication skills tend to decline as medical students progress through their medical education, and over time, doctors in training tend to lose their focus on holistic patient care.[7] Instead, more and more physicians are forced to follow standing protocols. Many physicians stated that they used guidelines to "guide" but not necessarily dictate their clinical decisions.[6] In order to follow hospital's guidelines and protocols, physicians are often faced with additional services and procedures that are causing a burden to them, especially in surgical and interventional areas.[5]

The result is that quality physicians and surgeons are burning out, leaving, retiring early, and/or are being forced out. Physicians who used electronic health records (EHRs) and computerized physician order entry (CPOE) had lower satisfaction with the amount of time spent on clerical tasks and higher rates of burnout on univariate analysis. On multivariable analysis, physicians who used EHRs or CPOE were less likely to be satisfied with the amount of time spent on clerical tasks after adjusting for age, sex, specialty, practice setting, and hours worked per week.[12] In short, delivery of medical and surgical care is increasingly out of physicians'/surgeons' hands, while patients have a little chance to express their opinion. Where did "patient first" and "do no harm" go in medicine?

To begin with, we should place the patient at the center of health care and ask if this program is in his or hers best interest. No matter whether it is a multibillion-hospital system, pharmaceutical company, or a solo practitioner, if its goal is self-serving instead of patient-only serving, it is a liability and not a solution. Data have shown that higher earning physicians earn more not by treating more patients but by offering more services per beneficiary. In Medicare's fee-for-service system, some physicians are collecting large fees by ordering services munificently.[3]

Involvement of physicians of different specialties for managing lumbar discogenic and radicular disorders may play a key factor in the decision-making process as to whether or not patients will ultimately undergo surgery. This factor likely results in a biased preference for proceeding to surgery when surgical specialists control the decision-making versus when chronic pain specialists do.[9] The so-called not-for-profit hospitals and health-care systems have become huge centers of profit making while delivering the worst outcomes in health care in decades. They are the bottlenecks of progress and, in an effort to protect their outdated and expensive delivery systems, they have resorted to stifling any competition or innovation that is considered threatening. In general, less competition means higher prices; one well-publicized symptom of the lack of competition in US health care is providers' ability to charge different prices for the same service.[1] Such competition and innovation is what the patient desperately needs to combat the rising costs of health care and usher the new innovations that improve outcomes. If we are serious about reforming health care, we should invite competition, embrace innovation, and let the free market principles that have driven every aspect of our society upward be allowed to do its magic and finally reform health care.

How can we restore the concepts and philosophies of "Patient First" and "Do No Harm"? Perhaps, the first step is to liberate the physicians from the business constraints so that they focus on providing the best care for their patients. We should restore the autonomy of medical providers so that they can do what is right for their patients, because technology, computers, smartphones, protocols, and guidelines are ineffective without "hands-on" care. There is no single protocol or textbook available to specifically treat every medical condition; they could guide the treatment but not replace physicians' assessment. It is important to understand that the goal of medicine is to make a diagnosis and not to engage in "trial and error" or penalize for pursuing medical testing to reach the correct diagnosis. We should not be financially penalized for spending time with our patients or for ordering the appropriate testing. The intermediates should not replace the physicians and should be a bridge but not the barrier to patients' access to physicians. Often, physicians are becoming signature taskers, as intermediates are the front line of patient treatment. The increase in bundling costs and ownership of corporations to distribute payments will only worsen patient care. Quality measures should be based on objective data and not just given as a patient satisfaction surveys. The medical oaths of "patient first" and "do no harm" should be applied not only by physicians but also by everyone working in the health-care systems. Quality health care should see a rise in clinical resources and cease the exponential rise in nonclinical burden. In addition, quality patient time should be a physician incentive and not a penalty due to a preexisting cap. For instance, spending time to perform an adequate surgery will get reimbursed at the same payment regardless of how long the surgery takes. The schools of medicine should reimplement the richness of clinical materials, open the doors for joining research, and encourage discoveries based on science rather than those of private industry. Finally, participation in continuing medical education (CME) activities to only receive credits should be also focused on improvement of care and new sciences on the horizon.

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