

Opinion

Individual vs. Societal Needs: What's a Physician to Do?

Unsustainable. It's a pretty popular song these days, being applied to global warming, foreign oil dependence and the growth in health care expenses.

Pretty much everyone agrees that we cannot continue devoting ever greater percentages of our gross domestic product to health care. By the time you are reading this, the congressional debate over health care reform should be up to fever pitch. Pessimism is rampant. Yet there is one bright spot, as outlined in a 2009 *New England Journal* perspective.¹ The authors note that during the period 1992 through 2006, overall Medicare spending (adjusted for inflation) increased by 3.5 percent annually. Yet during that same period, there was substantial regional per capita spending variation, e.g., Miami rose 5 percent annually, while San Francisco rose only 2.4 percent. It doesn't sound like that much variability, but when compounded over the 15-year span, it makes a huge difference. The differences remain even after careful adjustment for health status. The best explanation for the regional variation, according to other research by the authors, is a difference in physician behavior, especially in gray areas of testing and treatment decision making.

So where's the bright spot, you may ask? If we could reduce the 3.5 percent annual growth nationwide to the observed San Francisco rate, the

projected \$660 billion Medicare deficit in 2023 would become a \$758 billion surplus. That's enough to get a legislator's attention. That is why everyone is talking about structuring incentives for cost-effective physician behavior. Physician adherence to evidence-based clinical guidelines, like the Academy's *Preferred Practice Patterns*, will be critical to reducing the regional variations in Medicare spending between, say, Houston, Texas, and Salem, Ore.

"But wait," I hear often in online chatter, "we swore an oath to keep the good of each patient as our highest priority." Without question, it is the fundamental, core principle of our profession. And that principle must be at the center of any health reform legislation. But I do take exception to one tweet, "Either [the physician] takes care of the patient, or [s]he serves as a public health officer. To do both is to invoke a conflict of interest." Quite the contrary, my view is that we should be acting with a sense of societal responsibility even as we care for individual patients. The modern version of the Hippocratic oath coauthored by Louis Lasagna, MD, and used today in many medical schools reads, "I will remember that I remain a member of society, with special obligations to all my fellow human beings . . ." The manifestation of this may be leadership in day-to-day decisions, helping patients to understand when a conservative approach is preferable to a costly, but no

more effective, intensive strategy. Or it may involve choosing among effective glaucoma medicines with an eye to minimizing not just patient copays but also cost to the health care system. At the community level, physicians can argue against the need for growth of expensive, but duplicative, new facilities. Finally, acting as advocates for aspects of health care reform, we can espouse a wider, social perspective. Most of us are already doing these things, but we may not yet consciously attribute them to our role as ophthalmic ambassadors for public health.

1 Fisher, E. S. et al. *N Engl J Med* 2009;360: 849–852.



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