

## P E R S P E C T I V E

**My Dad Was Not A Prepaid Group Practice Patient**

A physician-writer reflects on his father's final illness and the lack of coordination in his father's care.

**by Fitzhugh Mullan**

**ABSTRACT:** The author's father was a psychiatrist, a concerned citizen, and a Medicare patient. He died recently after a prolonged illness during which a panoply of physicians cared for him in ways that were sometimes redundant, inefficient, and poorly coordinated. He was definitively not a prepaid group practice patient. The author reviews the growing body of evidence that suggests that physician density is associated with greater costs but not improved outcomes. He reflects on his father's concerns with equity in health care and how prepaid managed care might have provided more efficient and less expensive medical coverage for his father's final sickness.

**M**Y DAD DIED LAST YEAR at the age of ninety-one. He was a psychiatrist in private practice for most of his career. Over time, however, he became interested in the ethics of medical care and concerned with the distribution of health services in the United States. In latter years he taught group therapy to family practice residents and joined the liaison group on bioethics at the National Institutes of Health (NIH). Although the care he received in his final illness was good by clinical standards, I don't think he would have been happy about it.

The short story of Dad's illness is that at age ninety he was admitted to a hospital in Washington, D.C., with severe abdominal pain. His devoted general internist of many years had retired the year before, and his new internist was busy, disorganized, and did not like hospital work. It was a surgeon who admitted Dad to the hospital and who called a gastroenterologist in consultation. Together they diagnosed gall bladder disease and appendicitis, straight-

forward enough conditions but potentially lethal in a ninety-year-old. Before surgery, they called in a cardiologist and a pulmonologist to advise them about his heart during surgery and his lungs afterward.

Dad withstood the surgery, but his mind and body never really recovered. His pre-surgical confusion became permanent disorientation, his memory never returned, and his physical recovery was slow and partial at best. The surgeon provided excellent follow-up care. The cardiologist, pulmonologist, and gastroenterologist remained attentive. Because Dad continued to show signs of infection, the surgeon asked for an infectious disease consultation. Because of his continued confusion, the gastroenterologist asked for the advice of a psychiatrist (who treated him) and a neurologist (who did not), both of whom continued to visit Dad regularly. This herd of skilled clinicians had assembled itself with little planning and no coordination. A weekday morning in Dad's room during the latter part of his stay

---

*Fitzhugh Mullan (fmullan@projecthope.org) is a practicing physician and contributing editor of Health Affairs.*

was a social event with one affable physician after another stopping in.

The surgeon remained Dad's principal physician throughout his stay. Since Dad's internist was the one physician who seemed never to visit, we asked another general internist to "follow him," anticipating the need for a post-hospital physician. This latter physician joined the ranks of Dad's visitors but, arriving late as he had, did little to coordinate or manage the care. When it was decided to discharge Dad to a nursing home, the internist bid us farewell, explaining that he never made nursing home visits.

The surgeon did a good job of treating a frail, elderly man with a life-threatening surgical emergency. The variety of medical subspecialists who cared for Dad did creditable jobs, but their communication with one another and with us, his family, was haphazard at best. Most of the specialists involved continued to make regular rounds throughout Dad's hospitalization, writing notes (some of which were more legible than others) and ordering tests or procedures from time to time. No egregious errors were made, and although it was difficult for us to keep track of who was in charge of what, Dad probably left the hospital in as good a state of health as we might have hoped for.

### Typical Experience

Dad was not a prepaid group practice (PGP) patient. He had Medicare: traditional, fee-for-service, indemnity-based Medicare. Dad's care was unarguably generous but patently inefficient and doctor-intensive. Medicare paid the lion's share of the bill, and his Medigap policy covered most of the rest. My mother dutifully filed the masses of paperwork she received and paid the few bills that remained.

Yet Dad would not have been pleased with his hospital experience. He would have been disturbed because the poorly coordinated, specialist-intensive, unnecessarily expensive care that he received would have been at such

variance with the carefully managed PGP setting documented in Jonathan Weiner's paper. Fairness in the system was at the top of Dad's concerns. His life as a practitioner and his increasing interest in the ethics of medical care led him worry about the ability of U.S. medicine to reach all U.S. citizens and, in future years, to continue to provide for the elderly. He would have found Weiner's paper valuable because of the documented efficiency of the clinical workforce in the PGP setting. He would have known, as well, that his experience, not the PGP experience, was much more representative of the physician care of well-insured American patients.

**"The variability in the use of physicians is a core issue for the future of health care in the United States."**

### Examining Variations

The variability in the use of physicians is a core issue for the future of health care in the United States. Weiner's paper is one more piece of evidence that medical care can be delivered by a mix of providers that is far leaner than the norm in this country. John Wennberg and his colleagues have documented that the more than twofold variation in Medicare spending per enrollee in U.S. cities is attributable to specialty visits and hospitalizations.<sup>1</sup> Elliott Fisher and colleagues have demonstrated that the variation in costs of Medicare patients is explained largely by more inpatient-based and specialist-oriented pattern of practice observed in high-spending regions—regions that show no benefit in clinical outcomes.<sup>2</sup> David Goodman has shown similarly that the more than fourfold variation in the number of neonatologists per birth across U.S. communities provides no benefit beyond the most marginally served areas.<sup>3</sup> Weiner's work adds to these powerful analyses by demonstrating that PGPs provide care with a provider mix that is roughly 30 percent lower than the national provider-to-patient ratios. This finding should be of value to future discussions about health care reform and should give pause to those calling for the immediate expansion of the physician workforce.<sup>4</sup> By implication, it suggests that the unrestrained

conjunction of enthusiastic clinicians and well-financed patients makes for a costly and inefficient health care system—the one that my dad experienced.

### Epilogue

Dad died in the nursing home six months later, cared for by a geriatrician and a nurse practitioner. Terminal events are not easy, and I know Dad would have had a lot to say about everything he went through. The ethicist in him would surely have been disturbed about his Medicare hospitalization and the lavish inefficiency of his physician care. He would have appreciated the skills of the physicians who tended to him, but he also would have been disturbed by the extravagance of their numbers, the irrelevant visits, the overlapping roles, and the striking absence of coordination. I can hear him asking if some of his team couldn't usefully have spent time seeing other patients who needed services more than he did. He would have wanted his care to reflect good custodianship of the country's medical wealth. PGPs' use of physicians as documented by Weiner would seem to embody the essentials of such an approach.

### NOTES

1. J.E. Wennberg, E.S. Fisher, and J.S. Skinner, "Geography and the Debate over Medicare Reform," *Health Affairs*, 13 February 2002, [content.healthaffairs.org/cgi/content/abstract/hlthaff.w2.96](http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w2.96) (8 January 2003); J.E. Wennberg, "Unwarranted Variations in Healthcare Delivery: Implications for Academic Medical Centres," *British Medical Journal* 325, no. 7370 (2002): 961–964; and E.S. Fisher and J.E. Wennberg, "Health Care Quality, Geographic Variations, and the Challenge of Supply-Sensitive Care," *Perspectives in Biology and Medicine* 46, no. 1 (2003): 69–79.
2. E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine* 138, no. 4 (2003): 273–287; and "Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* 138, no. 4 (2003): 288–298.
3. D.C. Goodman et al., "The Relation between the Availability of Neonatal Intensive Care and Neonatal Mortality," *New England Journal of Medicine* 346, no. 20 (2002): 1538–1544.
4. R.A. Cooper et al., "Economic and Demographic Trends Signal an Impending Physician Shortage," *Health Affairs* (Jan/Feb 2002): 140–154.