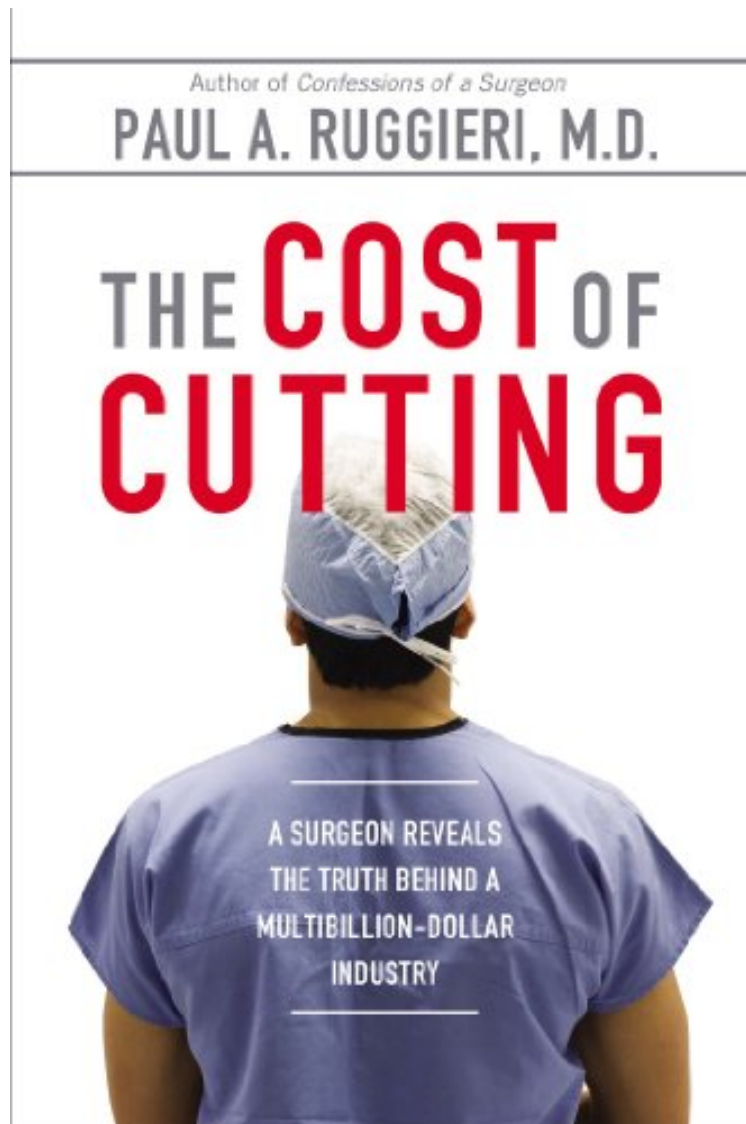


(Download free pdf) The Cost of Cutting: A Surgeon Reveals the Truth Behind a Multibillion-Dollar Industry

The Cost of Cutting: A Surgeon Reveals the Truth Behind a Multibillion-Dollar Industry

Paul A. Ruggieri

*ebooks | Download PDF | *ePub | DOC | audiobook*



 Download

 Read Online

#611606 in Books Ruggieri Paul A 2014-09-02 2014-09-02 Original language: English PDF # 1 8.30 x .70 x 5.40l, 1.00 #File Name: 0425272311320 pages The Cost of Cutting A Surgeon Reveals the Truth Behind a Multibillion Dollar Industry | File size: 79.Mb

Paul A. Ruggieri : The Cost of Cutting: A Surgeon Reveals the Truth Behind a Multibillion-Dollar Industry before purchasing it in order to gauge whether or not it would be worth my time, and all praised The Cost of Cutting: A Surgeon Reveals the Truth Behind a Multibillion-Dollar Industry:

4 of 4 people found the following review helpful. Essential reading for anyone interesting in the medical industry

By Peter J. Neame
In this sequel to his previous book, Dr Ruggieri looks at the economics of general surgery. It is certainly an eye opener, even for me; I work in the financial side of the medical industry. Sometimes he errs into what I would regard as CNN-like simplifications: "Many state-offered health insurance plans pay surgeons on the same level as Medicaid: twenty-nine cents for every dollar billed"; "Medicare pays close to thirty-eight cents on the dollar"; "Private insurance plans might approach sixty cents on the dollar" - this may be the case for his fee structure, but in fact the amount paid is a contracted amount, as rule, or a federally mandated amount. You can bill whatever you like and it won't alter what you get paid (unless you are insane enough to bill below the "allowed amount"). Sometimes, there is excessive repetition - these are both small quibbles, although they do make me wonder at the veracity of some of his numbers. The "cost" of a procedure is usually the billed amount, not the actual amount received by the physician and/or hospital. He points out that hospitals buying private physicians practices will only drive costs up as hospitals are usually paid more than private physicians while at the same time they have little or no interest in the classic patient/doctor relationship. Some people, of course, will prefer the new, more impersonal model. This book has many lessons that apply to all medical specialties. Three highlights for me were: 1. When you have insurance, the physician will have to accept a set fee for services - this can be the biggest benefit of insurance if you have a high deductible plan. There are insurances that do not do this ("we will pay 50% of your bill"), but they seem to be becoming, thankfully, very rare. 2. In high deductible plans, the hospital and the surgeon are in direct competition for the patient's money. 3. Many, well chosen, case studies that clarify the whys and wherefores for performing, or not performing, surgery. His conclusion is that under the current medical climate, patient choice will be reduced. Of course, choice has already been reduced - few people choose to need interventional medical care! On the other hand, as an example of the extraordinary topsy-turvy economics of medicine, until the affordable care act, medical complications after surgery actually increased profits for hospitals: "Abandon Hope, All Ye Who Enter Here"! Thankfully, this is being addressed by CMS/Medicare by refusal to pay for avoidable complications and reduction in pay for readmissions after short periods of time. Some of the more corrosive historical practices are steadily being changed - Dr Ruggieri discusses these changes and gives excellent advice on interpreting the publicly available data, which may not all be as it seems. He is reasonably even handed with the pros and cons of modern changes to the medical landscape. This is a denser book than his previous one, but overall, contains much more information about health policy and the changing landscape of medicine in the US. It is quite up-to-date - interesting to read his analysis of the literature on robotic surgery vs. laparoscopic surgery. Our local teaching University has been pushing robotic surgery hard (they invested an awful lot of money) and tout it as being "safer, fewer side effects, better recovery time, etc". They do not say what they are comparing it to - I'll bet it is open surgery! He ends with the thought "what is a good surgeon worth?". Another conclusion that I took away, as I'm sure I was supposed to, was "How do you find a good surgeon, assuming you have a choice?" Well worth reading for its insights into medicine as a business.

1 of 1 people found the following review helpful. Thoughtful and thought-provoking

By Gary Fradin
I sensed an underlying tension in Paul Ruggieri's excellent and engaging book, between his desire to see medical care as a human right and today's financial requirements that he treat it as a product. His chapter 'Can Your Surgeon Afford to Operate On You' opened my eyes to the constraints placed on surgeons by routine business practices; I wonder where and how chronically ill Medicaid recipients can get the high quality care they need, routinely available to people with commercial coverage. His 'Human Cost of Quality' discussion highlighted the need for outcome focused discussions between doctors and patients, and for outcome-based care quality metrics. I don't know if the ACA will improve our system much - it may - but I'm sure that more shared-decision-making will. Dr. Ruggieri's book provides background information necessary for wise patients to participate more fully in their medical decisions. Would that all American had access to this information and to high quality insurance to finance their medical needs.

5 of 6 people found the following review helpful. It's About Time Physicians Stood Up!

By Aleta Detwiler
As a practicing general dentist for 30+ years I have watched physicians being racked over the coals by insurance companies, hospitals and patients. These brilliant men and women who have sacrificed so much during their training in terms of time and lost-earning years as well as the loans for education (in most cases) have been beaten senseless in the name of altruism. As a group, medical doctors have allowed this present situation to evolve with little resistance. It is past time for physicians to follow the lead of Dr. Paul Ruggieri and develop a way out of this situation that is daily becoming more alarming. Education of the public as he has done is a start. Who is going to help? Although I have watched the things he wrote about happen from my sideline position, I had no idea of the various ways insurance companies, politicians and hospitals have directed medical care to its present mess. I can see it happening in dentistry, at a smaller scale. I have been appalled at the reimbursement rate for dental work dropping in the light of increasing expenses, staff salaries, etc. I must "cherry pick" patients when the insurance reimbursement rate does not cover my costs, let alone any salary for me. I am only fixing teeth. Anyone can live without teeth, although the quality of life is the bigger issue. However, when my reimbursement rate is greater than someone respecting a colon, I am appalled. Everyone should be. Where is the outcry from fellow physicians? From patients? **READ THIS BOOK.....** Not for reading pleasure (although it is well written) but to educate yourself. Thank you, Dr. Ruggieri for your time researching and writing this book. Th

Why is surgery so expensive? Surgeon Paul A. Ruggieri reveals little-known truths about his profession and the hidden flaws of our healthcare system in this compelling and troubling account of real patients, real doctors, and how money influences medical decisions behind the scenes. Even many well-informed patients have no idea what may be contributing to the cost of their surgery. With up-to-date research and stories from his practice, Ruggieri shows how business arrangements among hospitals, insurance companies, and surgeons affect who gets treatment and whether they get the right treatment. Pulling back the curtain from the hospital bed, he explains how to safeguard one's own health (and finances), and how America can make surgery more affordable for all without sacrificing quality care.

Surgeon Ruggieri tutors readers on the economic forces that make the surgical theater tick. Ruggieri is a fine storyteller, which is a good thing, for although he peppers the book with dramatic anecdotes from his practice, his real exploration focuses on the financial side of the medical equation... Top-shelf instruction on the mechanics of the medical economy. Kirkus SA vital conversation about money in medicine that we have not had, but desperately need to have. A deeply personal and powerful analysis with sweeping implications for addressing waste in medicine. Dr. Ruggieri challenges why healthcare continues to have an expensive carve-out to the same accountably principles that govern other industries. He offers serious ways to cut waste and increase value by making medicine more patient-centered, more efficient, and more transparent. Marty Makary MD, Johns Hopkins surgeon and author of *Unaccountable* Praise for *Confessions of a Surgeon* Honest and angry, this cutting memoir by a midcareer surgeon feels like an act of penitence. Booklist Looks hard at a profession that is changing in ways that Ruggieri does not always find to be positive[a] look into a corner of medicine we seldom see. Providence Journal About the Author Paul A. Ruggieri, M.D., is a board-certified general/laparoscopic surgeon and the author of books, including *Confessions of a Surgeon*. Excerpt. Reprinted by permission. All rights reserved. from *THE COST OF CUTTING* INTRODUCTION I had my first inkling that I wanted to be a surgeon before I was even accepted into medical school. Once I was there, it wasn't long before I knew surgery was my calling. That was more than twenty-five years ago and every day (well, almost every day) since then I've been able to say, I love what I do. As a general surgeon, using my hands, my brain, and the tools of surgery, I can make a difference in the quality of a person's life every time I step into the operating room. Sometimes I can even save a life. I'm profoundly grateful for the opportunity. A couple of years ago I wrote a book about what goes on inside an operating room from a surgeon's perspective. I wanted to take people into that mysterious world where a day's work can ricochet from the mundane (varicose vein removal) to the sublime (repairing a torn artery before the person bleeds to death) in a matter of minutes. Those moments when something truly exceptional happens in the operating room, and even the less exciting ones, are what keep me and my colleagues doing what we do. The work itself is truly the reward as is the gratitude of our patients. Why, then, have I written a book about the money side of the equation? Isn't money supposed to be anathema to the high principles of the medical profession? After all, we're not stockbrokers, we're healers. Traditionally, it's been almost unseemly to mention money in the same breath as patient care. But a new conversation is taking place in our country, and it's all about money and healthcare. None of us can get away from it, including those of us who work as physicians and surgeons. And maybe that's a good thing. I'm finding for the first time in my professional life that doctors are talking openly with each other about reimbursement, about expenses, about the challenge of running a viable practice while taking on more and more Medicare patients as the baby boom generation turns sixty-five. As the Affordable Care Act (ACA) kicks in, the conversation about the cost of providing care in America has become even more important. And more frantic. Who will be covered? What will it cost? How will we as a country afford it? How does all of this relate to quality or does it? A lot of contradictory points of view are being put forth. It's a topic worth careful consideration. And that's why I've written this book. Currently, the United States spends more than \$2.7 trillion a year on healthcare. This figure translates to more than 17 percent of gross domestic product (GDP) and more than any other nation on earth spends on delivering medical services. A healthy piece of this \$2.7 trillion pie is spent by private insurers and the federal government on reimbursement for operations and all the related expenses: surgeon fees, anesthesia fees, operating room fees, recovery room fees, hospital inpatient fees, and the state-of-the-art equipment used during surgery. Surgical procedures, more than any other aspect of healthcare, generate revenue. Big revenue. Operations are the lifeblood of hospitals. And of surgeons. Surgeons do not make a living seeing patients in the office; they make a living seeing patients in the operating room. Without busy operating rooms, many hospitals would dry up, closing their doors and taking away other important (nonsurgical) services as well. Without operating rooms full of busy surgeons, medical device companies (big international for-profit companies that produce a plethora of equipment used during surgery, such as artificial joints, mesh, robots, cardiac stents, sutures, surgical stapling devices, and laparoscopic equipment) could not survive. Nor could they face their shareholders. With more than fifty million operations performed in this country every year, surgery is big business. Surgery is an engine that compensates surgeons performing their craft, supports hospitals promoting their surgical services, and profits medical device companies. Unfortunately, all this money carries with it power and influence. When it comes to medical decision making, power and influence are not what you want motivating your surgeon, your hospital, or your insurance company. I believe this taboo topic should be part of our national discussion as we shape the future of healthcare. Historically, surgeons and hospitals have benefited

financially by producing greater operating room volume, not necessarily greater quality. Surgeons know this, anesthesiologists know this, insurance companies know this, and hospital administrators especially know this. Ironically, the only ones who are unaware of the enormous amounts of money generated from their operations are the patients about to be wheeled into the operating room. It does not matter whether your heart is being bypassed, your stomach stapled, your knee scoped, your uterus removed, your spine fused, or your hernia repaired; a long line of healthcare providers, hospital administrators, insurance company executives, and medical device company big shots are profiting before, during, and after your operation. Maybe that's as it should be. Money must be made from surgery or there would be no surgical care at all. The question before the nation is, How much is that worth? Over the last ten years, healthcare costs have spiraled out of control. The average person knows something is awry but not exactly what, or how to address the problem. What we do know is that there is a limit to the amount of federal money we are comfortable designating for medical care, and insurance companies are in business to make money. We want greater access to care and we want quality care and we want lower insurance premiums. So whose going to foot the bill for all that quality care? The ACA means greater access to care for more of the population, but it also means even greater government scrutiny on healthcare costs, and it has already resulted in significant reductions in reimbursements to providers, including surgeons. In many ways, this scrutiny is a good thing. To remain viable, however, hospitals in every community across this country are consolidating to gain patient market share and buying up primary care doctors and specialists alike. This shopping spree is an attempt to control referrals to their operating rooms and retain patients in their network. Retention is the battle cry of hospitals today. As a potential patient, you are affected by all this. Hospitals' attempts to control surgical referrals affect your choice of surgeon. Insurance companies are encroaching on your choices, too, with limited healthcare plans and provider networks. Sure, you can still choose your surgeon, but it will cost you sky-high deductibles if he or she is an out of network provider. If you're very lucky, you may never need to see the inside of an operating room. But even if fate is that kind to you, the cost of healthcare and how it will be provided in this country is something that should matter to all of us. I don't claim to have all the answers to this puzzle, but I do hope the information and perspectives offered in this book will be enlightening. I hope you'll gain insights that will get you thinking about this topic in a new way. Meanwhile, I look forward to getting back to what I love to do.

PAUL A. RUGGIERI, M.D., F.A.C.S.

The woman seated on the exam table was lean and fit and seemed to be enjoying perusing one of the magazines from our slightly out-of-date offerings. She looked like she was in her midforties; her chart showed her age to be fifty-two. Her face did not express any distress and when she returned my greeting she spoke in a clear, friendly tone. As I scanned her medical history, the portrait of a person in good health came into view: her lab work, blood pressure, weight: All were excellent. Healthy and thin are two adjectives I do not often use to describe my patients. Why was this woman in my office? Several weeks earlier, it turned out, her primary care physician had ordered an abdominal CT scan to investigate a nagging pain that he hadn't been able to diagnose. Eureka: The radiologist reviewing the scan noticed gallstones. Mystery solved. The patient (we'll call her Mrs. Brogan) was subsequently referred to me for a surgical opinion, a consultation to determine whether surgery could help. As I performed the physical exam, I questioned her and soon concluded that her gallbladder was working perfectly. While some of her symptoms were vague and nonspecific, the gallstones found during the CT were what we in medicine call an incidental finding, nothing more. The true source of Mrs. Brogan's pain had yet to be determined. An incidental finding happens when an apparent abnormality of some kind unrelated to the source of the person's symptoms is discovered during a diagnostic imaging exam. For example, if a CT scan of the abdomen is ordered to help with the diagnosis of a bowel problem and the radiologist notices a dark area, a density, on the kidney, that information becomes part of the report and is considered an incidental finding. Similarly, if a CT scan of the chest for diagnosis of coronary artery disease reveals a nodule in the lung, that incidental finding is shared with the referring physician and, ultimately, with the patient. Let the testing (and worrying) begin. Over the past fifteen years there has been a dramatic increase in the use of two sophisticated diagnostic imaging tools: CT and MRI scans. CT (often referred to as a CAT scan), stands for computerized (or computer-aided) tomography, which uses x-ray technology. MRI, which stands for magnetic resonance imaging, uses a magnetic field and radio waves. Both create incredibly detailed views of the organs and soft tissue. According to the Radiological Society of North America (RSNA), while between three and four million CT scans were performed in 1995, seventy million were done in 2010. A report published in the *Journal of the American Medical Association (JAMA)* in 2012 showed a 400 percent increase in the use of MRIs during this same period. It is no wonder, then, that incidental findings are becoming more common and surgery as a result of them is on the rise. While the advance of technology has tremendous benefits in medicine, the information these tools provide can present problems as well. For example, according to the RSNA, one-third or more of all CT scans will reveal incidental findings, yet fewer than 1 percent of these abnormalities are cancer or in need of any medical treatment. Where is the problem in that? you may be wondering. Knowledge is power, is it not? The problem is that once the radiologist spots the abnormality, he or she will most likely include it in the report. (Seasoned radiologists struggle with nonspecific incidental findings and whether to say anything at all. Frequently, the decision to report them is heavily influenced by the ever-present shadow of a malpractice lawsuit.) This often means your doctor must share that news with you, causing you anxiety and necessitating further tests, exposing you to more radiation and

often a visit to an operating room for a surgical biopsy. By the way, the phenomenon of incidental findings is especially prevalent in the Medicare population (those age sixty-five and over). One study, published in the American Journal of Roentgenology in 2005, showed incidental findings to be as high as 75 percent in 259 individuals over age fifty who underwent CT scans. The reason: An aging body coupled with technology powerful enough to produce high-definition images of structures doctors have never seen before is a surefire recipe for incidental findings. Pandora's box has been opened. There is, of course, a financial cost for all this information. Americans now spend an estimated \$100 billion a year on medical imaging. But more important than the cost in dollars and cents is the cost to a person's quality of life. As H. Gilbert Welch, M.D., noted in his book, *Overdiagnosed*, imaging technologies are very helpful in finding the abnormalities that are making patients sick. But they are also increasingly able to find abnormalities in people who are well, a vicious cycle he refers to as seeing more, finding more, and doing more. The studies cited in Welch's book are provocative; it's difficult to acknowledge that the number of individuals who are hurt by unnecessary medical treatment is far greater than the number helped by the advances in diagnostic imaging, but that's what the numbers show. To take a closer look, consider another study from the journal *Health Affairs* in 2009 looking at how the increased use of MRIs can lead to potentially unnecessary surgery. This data showed that as the use of MRIs for generalized back pain increased, more spine abnormalities were detected. Whether these abnormalities were the true cause of the back pain is unclear. Yet the subsequent increase in back surgery correlates with the increase in MRI diagnostic imaging, despite the lack of definitive evidence that surgery would be beneficial. What that means is a significant number of individuals underwent major surgery on their spines (ranging from a laminectomy to spinal fusion) and yet continued to experience the pain that precipitated the MRI or, even worse, a more severe and disabling pain. Doctors order diagnostic imaging exams for the best of reasons. The results can be definitive and lifesaving. But they can also be equivocal, unclear. What you, the prospective patient, need to understand is that in some ways your doctor is a detective searching for clues, and what's wrong is not always immediately clear. Incidental findings are often red herrings, diverting attention from the real problem.

Back to Mrs. Brogan. I had in front of me a woman whose primary care physician had told her of the gallstones revealed on her CT scan. He had recommended that she seek a surgical opinion with me, telling his patient, I can send you to a surgeon who will try to find any reason to operate on you. I can also send you to a surgeon who will find any excuse not to operate on you. Or I can send you to Dr. Ruggieri, who is somewhere in between. Mrs. Brogan was free of underlying conditions (obesity or a chronic disease such as diabetes that can cause complications during what is usually a straightforward operation). And she was willing. As a matter of fact, when I told her there was nothing wrong with her gallbladder, she said, Why not just take the thing out? I don't need it anyway, do I? All that and she had very good health insurance. Reimbursement would not be a problem. I had an opening in my schedule that week.... For a brief moment and this is difficult to admit I found myself tempted to schedule the surgery. A completely unnecessary surgery. The operation would have taken me twenty stress-free minutes, Mrs. Brogan would have gone home a few hours after the operation, and I would have been paid close to \$1,000. The only problem: There was no medical reason to do so. Yes, the CT study had revealed gallstones. But they were totally asymptomatic, which is to say they were not the source of the pain she had been experiencing. Most likely, the gallstones would never in her lifetime become a problem. Mrs. Brogan's referring primary care physician had recommended the surgery based on his extensive workup. (He also had no idea where to go next.) He was convinced the gallbladder had to be the source of her pain since the rest of her workup had turned up nothing. Mrs. Brogan had decided that the years of vague left-sided (sometimes right-sided) abdominal pain must be gallstones. All I had to do was recommend surgery. And, like so many people who consult with me, she was of the school of thought that says, If you don't need it, remove it. The only problem: In my mind, there was no solid medical reason to perform surgery. I was, however, not deaf to the nonmedical reasons to schedule the surgery. Mrs. Brogan wanted it; I wanted to please her referring physician; and as a self-employed surgeon, I needed to earn a living and resist turning away potential business. Yet... the gallstones discovered on the patient's CT scan were, in my judgment, strictly an incidental finding, not the cause of her abdominal pain. Despite the report of gallstones, Mrs. Brogan's clinical history and physical exam were not consistent with gallstone pain. All of us—her primary care physician, the radiologist who read the CT scan, and I—were missing something. Something else was the source of Mrs. Brogan's pain; we just didn't know what it was. I believed her gallstones were asymptomatic, and I reassured her they were no threat. She was, as I explained, one of the millions of Americans walking around with an incidental finding. She did not need to see the overhead lights of an operating room.

According to the University of Michigan Center for Healthcare Outcomes and Policy, unnecessary surgery costs the U.S. healthcare system over \$150 billion a year. This is not a new problem. As far back as 1974, a congressional subcommittee report estimated that more than 2.4 million patients a year underwent unnecessary surgery (resulting in twelve thousand deaths). Today it's estimated that 10 to 20 percent of all operations are not needed. Of course, surgery is not the only way we waste our healthcare dollars; the Institute of Medicine uncovered \$750 billion in unnecessary healthcare spending in 2009. Of this, more than \$130 billion was spent on higher-cost procedures, such as operations. The cost of unnecessary surgery that can't be calculated is the price to the individual in lost days at home and work; emotional and physical suffering; and the risks associated with anesthesia, surgical site infection, and medication side effects—not to mention the possibility that the person will become

one of the 100,000 a year seriously harmed by a medical error during a hospital stay. Mrs. Brogans story is not unusual in my profession. Every day I evaluate men and women who come to me with a variety of complaints, all believing they are potential candidates for surgery. Some, frankly, do not need surgery two in four of the new patients I see should be treated in other ways. For others, the problem is obvious and treatable by an operation. You may find this picture contradictory. Surgeons, including me, need to operate to make a living. When I perform surgery, I am reimbursed by insurance companies for the service I provide. So why would we turn away business? The answer lies in our commitment to first, do no harm. When I sit with a prospective surgical patient and recommend an operation, my decision has enormous consequences, both personal and financial, that will affect both of us. What if despite my best intentions, I am wrong in my judgment? What if I mistakenly subject that person to the unnecessary risk of surgery for no true benefit? What financial burdens will I be subjecting the patient to (not to mention the American healthcare system)? What if there is a poor outcome, with complications? A surgeon's recommendation to take a person to the operating room should be solely influenced by medical facts, sound judgment, and experience. However, particularly today, other influences are weighing on the surgical decision-making process. Nowadays, surgeons are more pressured by business factors than ever before they feel compelled to keep hospital operating rooms busy, to keep their practices going, and to maintain a living. After twenty years as a surgeon, I can say this: The line between operating for love and operating for money isn't as distinct as it once was. The reality is that some surgeons (and hospitals) are more motivated by money than by the Hippocratic oath they promised to uphold. As a young newly minted general surgeon starting out, I was ready to operate, ready to make a living by improving lives. I was eager to conquer disease, ambitious in my desire to help all comers, and ready to take full responsibility for every person who walked through my office door. For me (and my colleagues back then), being a surgeon was not about money. We knew we were in for a nice pay raise once we left our residencies and started operating on our own, but we didn't talk about it. We knew we were going to upgrade our standard of living significantly. While the subject of making money was never openly discussed, we assumed we were going to do well. Frankly, many of us thought we deserved it, given the debt we had accumulated and the personal sacrifices we had made during training. The saying that doctors make poor businesspeople has some truth to it. Even today, during medical school and training, there is little acknowledgment of the business side of a surgical practice. We don't get an insight into the costs, the profits, or how to maximize your value. Appropriately enough, the focus for interns and residents remains on becoming competent surgeons. My mentors believed that the surgical profession was one of altruism; to talk about business and reimbursement in the same breath as the best way to take out a colon cancer would have been heresy. I believe that this perspective has contributed to the shortage and dissatisfaction in my profession today. Just as sad, the failure to understand the business side of a surgical career early on negatively affects patient care. I believe that most surgeons entering their careers are committed to a love of helping others and to practicing the highest quality of surgical care possible. I do not believe they are committed to their careers for the love of money. If they are, they will ultimately become hostages to it. Our focus when we are starting out is doing the best work we can; it takes a few years at least to begin to be able to earn more than a set salary. When I took my first job in a private practice, I signed a contract guaranteeing me a salary for two years as I built my referring network and patient loyalty. Because I was an employee of a private group, any monies I generated beyond my salary went to my colleagues. I was there to help cover some of their business operating expenses while reaping the benefits of practicing under the umbrella of my established colleagues. It was a fair arrangement. My group would take the risk of bringing on an untested surgeon, and I would have the security of a guaranteed wage. After two years, if my partners found my personality, quality of work, and ability to generate business acceptable, I would be offered a full partnership. In some settings, this offer does not come cheap. It is not uncommon for a new colleague to have to buy in to the practice to become a partner. This buy-in can cost from \$5,000 to \$100,000, depending on the region of the country (and the scruples of the practice). Whatever the cost, it's a price many of us pay (often, paying over time) because the alternative packing up and trying to reestablish a practice somewhere else is less appealing. The buy-in money goes directly into the pockets of your new partners and is all perfectly legal. What you are truly buying is the ability to work as hard as your ambition drives you, and the opportunity to make as much money as you can. As a surgeon in private practice at a community hospital, I am reimbursed directly by the patient's health insurance carrier for any operation I perform. I receive one global payment to cover the surgery itself plus all the care I provide afterward. If I do not have an active practice repairing hernias, removing gallbladders, cutting out colon cancers, operating on bowel obstructions, or removing cancerous thyroid tumors, I do not get paid. It's the same for all surgeons in private practice; if an orthopedic surgeon isn't busy replacing joints or repairing ligaments, he or she is not getting paid. For all of us, the busier you are (the more operations you perform), the more money you make. The fee-for-service reimbursement system for surgeons rewards quantity, not quality. Some say this system is flawed, that it encourages surgeons to operate as much as possible, perhaps even tempts them to perform unnecessary surgeries. Others point to the fee-for-service system as a major contributor to the rising cost of healthcare. I believe there is some truth to both of these concerns. As members of an independent, private group (as of this writing), my colleagues and I are partners in a business. It is a business in which we own equal shares. We share expenses, most of which comprise employee payroll, office rent, and malpractice insurance. The

diverse functions of a surgical practice mean we need to employ a staff with a variety of skills, including medical assistants, third-party billing experts, and administrative staff for filing, scheduling, and follow-up. Its expensive. As in any business, the income we generate which is only from performing surgery must exceed our monthly expenses or we will not remain viable. By far, the most important business function within any private practice today is billing. The incredibly complex maze surgeons must navigate to get reimbursed for services rendered, whether from the federal government or private insurance, means a savvy billing department is crucial to a successful practice. When my senior partner started out in surgical practice more than thirty years ago, his billing system consisted of a pen, stationery, an envelope, and a stamp. After performing a surgery, he would instruct his secretary to write a letter to the insurance company on office stationery, describing the operation and how much he was charging for it. The letter would be mailed to the appropriate address, and several weeks later a check would arrive in the requested amount. It was that simple. There were no questions asked, no denying payment, no additional paperwork, and no pressure. You got full reimbursement for your services. That was the gilded age of surgical billing, and it gave surgeons a generous, uncomplicated living. Those days are long over. Today's complex system of reimbursement is very different, virtually unrecognizable to many surgeons, including me. In order for surgeons (and all physicians) to get reimbursed for services, a specific code number (CPT code) corresponding to the service performed has to be electronically filed with the appropriate modifier codes and documentation. Once these are filed, it can take up to six weeks to get reimbursed. If the surgical claim gets rejected for improper coding or lack of documentation, it has to be refiled. Months could pass before any payment is approved and made. Despite being equal partners in a surgical business, colleagues in the same practice can often earn very different salaries. For instance, in my practice, I am fourth on the income-generation chart. Several of my colleagues perform more operations than I do (by choice), and generate more income because of it. This isn't a bad thing. Some surgeons work harder at promoting themselves, advertising their unique skills and their quality work, and make themselves available day or night. But today, selling surgery has become more of a necessity. Like any other service business, surgeons have clients—patients, referring physicians, hospital systems, and insurance companies whose needs must be met. Some of these needs have nothing to do with actual patient care and are subtly eroding the ethics of my profession. The voices of hospital administrators, medical device sales reps, and insurance companies are crowding in on a surgeon's choices. That is, until I'm standing in the OR, scalpel in hand. Then, suddenly, I am alone in the decision-making process.

Mrs. Keeneland was a fifty-four-year-old woman who had been referred to me by her primary care physician because of her complaint of constant, chronic abdominal pain over the last five years. She had already been seen by an array of specialists and had undergone a battery of diagnostic imaging studies, including upper and lower endoscopy, all of which had resulted in no conclusive diagnosis. She had even swallowed a tiny camera (purposely) that had traversed through her small and large bowel, taking pictures along the way, before it exited into the toilet. Once again, nothing. Yet her pain persisted. Her primary care physician, one of my major referral sources, was at a dead end. As I read her medical history before entering the exam room, I soon concluded that previous operations were the cause of her pain.

Dr. Ruggieri, you need to help me, Mrs. Keeneland began before I could even say hello. I can't live with this pain anymore. She clutched her abdomen. I have had several operations in the last ten years, including a colon resection and multiple hernia repairs, some with mesh. I could see she knew the lingo. My primary care doctor tells me I have scar tissue that's causing this pain. He said you can remove it, and the pain will be gone. He told me I have no other choice but surgery. She started to cry. No one else can do anything for me. I just can't live like this anymore.

I examined Mrs. Keeneland's abdomen, covered with old surgical scars crisscrossing like train tracks. By laying my hands on a patient's abdomen, I can often discover a lot about the previous operations from the length, width, texture, and location of the surgical scars. The one fact I cannot discern is whether the operations were medically necessary. As my fingertips read her scars, like a blind person reading Braille, my mind was coming to a conclusion about Mrs. Keeneland's prognosis. Adhesions, more commonly known as scar tissue, are an unwanted by-product of any operation. They are part of the natural healing process after surgery or any inflammatory process, such as acute appendicitis or endometriosis, and can occur anywhere in the body. Every time I venture into a patient's abdomen, I leave scar tissue behind, regardless of what I have removed. After intestine is manipulated during an operation, adhesions form, causing everything to stick together. If I reenter that patient's abdomen for another reason, the scar tissue gets worse and the risk of complications increases, especially the risk of bowel injury. Adhesions are the most common reason for surgery of small bowel obstructions and cost the healthcare system many billions of dollars a year. Depending on the study you read, the overall treatment for adhesion-related complications has been estimated at \$1.3 to \$2 billion per year. Adhesions are also presumed to be one of the most common causes of chronic, intra-abdominal pain in patients today. We cannot measure them, image them, or even document their existence without another operation. It's a catch-22 situation. There is also no curative operation to remove adhesions. The ideal treatment is to avoid intra-abdominal surgery if at all possible. In the long run, repeat abdominal surgery to cut adhesions has not been proven to be effective, has an increased risk of complications, and is costly to the system. Only a minority of patients get relief after surgery to cut adhesions and free up the small intestine. Much of this relief is temporary at best. A study published in the journal *Lancet* in 2003 compared laparoscopic adhesiolysis (cutting of scar tissue) to diagnostic laparoscopy (no adhesiolysis) for the treatment of chronic abdominal

pain. Both groups of patients had pain relief with no difference between them, suggesting that the placebo effect of diagnostic laparoscopy worked just as well as the actual adhesiolysis. Mrs. Keeneland, I began, I believe your pain has many components, one possibly being adhesions inside your abdomen, scar tissue caused by multiple operations over the years. I paused, knowing she wasn't going to like what I had to say next. Unfortunately, there is nothing I can do to make your situation any better. In my opinion, surgery is not the answer. It is too risky. A clear benefit is just not there. She took a deep breath and dried her eyes. I continued, There may be someone else I can have you see to manage your pain. I had barely finished speaking when Mrs. Keeneland got up and, without making eye contact, walked toward the exam room door. Before I could say another word she was gone, slamming the door behind her. She had expected me to schedule surgery, based on the optimistic conversation she had with her physician. She was tired and in pain, and her reaction was understandable. Could I have operated on Mrs. Keeneland? Yes, of course. I could have explored her abdomen, cutting scar tissue to free up her intestines with the small hope of lessening her pain. I knew the scar tissue would be there. I also knew that trying to cut it out would not actually help. Exploring abdomens is what I do for a living. Despite the real risks of bowel perforation and prolonged hospitalization, Mrs. Keeneland would have consented gladly to an operation if I had presented her chances of success with a little optimism. I could have documented specific clinical points regarding her diagnosis, enough to satisfy her insurance company to approve the surgery. For the operation itself, I would have been paid close to \$1,500 (depending on her insurance) for several hours work (depending on how bad the scar tissue was). The hospital where the surgery took place would have received ten times that amount, depending on her length of stay and whether there were any complications. Based on my experience, the risks of operating on Mrs. Keeneland far outweighed the possible benefits despite the fact that I would be reimbursed regardless of her outcome. As I watched Mrs. Keeneland leave my exam room, I had no doubt she would find another surgeon who would calculate her risk differently, evaluate her chances of a good outcome differently, and offer her what she wanted. An operation. The world is gray, Jack. That line, from the movie *A Clear and Present Danger*, about why the lines between right and wrong are blurred while the outcome is crystal clear, could just as easily be taken from one of my practice's weekly meetings. In surgery, there are often clinical situations where a patient's problem falls into a gray zone. When that happens, the decision to operate (or not) becomes somewhat arbitrary, even affected by past experiences (both good and bad). It can also be susceptible to nonclinical influences. For instance, if a patient of mine has a colon cancer, or a thyroid cancer, the problem is a very clear and present danger. In the situation of most cancers, the decision to treat with surgery is not gray. It is black-and-white, based on sound clinical outcome studies. In other disease states, however, the decision to treat with an operation is not backed by definitive data, leaving room for the surgeon to determine the best course of action. Many of these conditions are common and operations to treat them are performed on a regular basis. Mrs. Keeneland, with her pain and adhesions, falls into this category. A person with an asymptomatic inguinal hernia, incidentally found on a routine physical examination, will undoubtedly elicit different surgical recommendations from two or three different consultations. Some surgeons will want to repair it, while others will discuss the risks and benefits and urge the patient to wait and see if it becomes symptomatic. As a surgeon in private practice, I work for myself even though I practice within a group of six surgeons under one financial roof. Within my group, I am my own independent private contractor and can offer surgical services to anyone who walks through my office door. I am not guaranteed a salary by anyone today, next month, or next year. I am not guaranteed referrals, either. I am not guaranteed a retirement income unless I put away money every year. While I am in the business of treating surgical disease, trying to improve the quality of life of my patients with my skills as a surgeon, I am also in the business of earning an income, an income generated by carefully deciding who needs to go to the operating room and who does not. And this is where the balancing act of medical ethics comes into play. For most surgeons, the decision to take someone to the operating room is based on knowledge, experience, ethics, and the best interest of the patient. It is a purely professional medical decision, untainted by other influences. It is unrealistic, however, not to acknowledge today's surgical workplace, where surgeons are under increasing pressure to generate income. Surgeons are fighting to maintain their incomes in the face of declining reimbursements. For instance, fifteen years ago private insurance companies reimbursed surgeons (and gastroenterologists) close to \$1,200 for a routine colonoscopy. Today, that number is under \$350. Cardiac surgeons have seen their fees for heart bypass surgery decline by 200 percent over the same time period. Now, I'll pause here to say that I understand why most of the population sees surgeons as already making a lot of money, maybe too much money. I suspect most would have no sympathy for a general surgeon making over \$300,000 a year and crying about reimbursement rates, or an orthopedic surgeon making \$500,000 a year, a neurosurgeon making \$750,000, or even a cardiac surgeon making close to \$1 million. So, you doctors might be making a little less these days? So what!?! Compared to the average American, our income makes us very rich indeed. But many of us are still fighting to remain self-employed. While we pay our high insurance premiums and plan for our retirement, we have to figure out how to do that when government and commercial health insurance companies are paying less and less for our services. The pressure to operate can also originate from patients themselves. There are times when I know a surgery would be a fifty-fifty proposition, at best, for a successful result. In those instances, I have to say, No, surgery is not a good idea, despite ardent pleas from the patient as with Mrs. Keeneland. It's not an easy conversation to have. There is also

pressure from referring physicians; many expect me to use my surgical skills to solve the problem and make the patient completely better. And the fact is, if I am conservative too often, some referring physicians will look elsewhere for a surgeon. In the simplest terms, not scheduling surgery for a referring physician's patient means you've just put a hot potato back in his lap. He's not going to be happy about it. Employed, salaried surgeons (especially those who work for corporate entities and hospital systems) feel constant pressure to earn enough to meet their salary and contractual quotas. Many of them are working in an environment where the threat of being replaced is real. It's a picture that resembles the cutthroat world of commercial sales more than the world of medicine. Surgical decision making has got to be affected, even if only a little. The pressure to operate can also come from within surgeons themselves. Every one of us has a level of experience, a comfort zone. We know what we do well. Yet for many of us, it is difficult to admit our limitations and pass up an opportunity to operate, giving away business, even when we should. I have observed surgeons performing operations they haven't done in years, causing minor and major complications for their unsuspecting patients. Ego, arrogance, greed? Call it what you wish. I call it criminal. It is difficult to acknowledge a lack of skill or experience, to oneself or a patient. It is difficult to turn down an operation (especially one that pays well) that you probably could perform but haven't done in the last year. It is difficult to admit to a referring physician that his patient would be better off in the hands of another surgeon. But it is the right thing to do. Every month, I choose not to operate on a fair number of patients because I have concluded that surgery is not medically necessary. Most surgeons think the same way. Other elements that factor into my decision include the overall health of the patient and his or her ability to tolerate an operation, the risk for complications or a poor outcome, the likelihood of success, and my own experience with whatever operation the person requires. It's a multifaceted consideration. The one thing that does not factor in is the type of health insurance the person has. In our practice, my colleagues and I take all types of insurance, from the worst to the best payers. I (and most surgeons in practice today) am keenly aware of what each insurance plan reimburses for every operation I can perform. (Why shouldn't I be? From a business standpoint, I need to be aware of reimbursement.) As a general surgeon, I know that my best-paying operations involve major abdominal surgery (colon resections, stomach resections). I know that laparoscopic procedures (the use of very small incisions and fiber optics) reimburse less than regular open surgery (larger incisions that allow the surgeon to see the entire area and organs). Reimbursement for robotic procedures is similar to that for traditional laparoscopic procedures. I have no doubt that orthopedic surgeons are aware of what they receive for joint replacements; neurosurgeons for spinal fusions; heart surgeons for bypass operations; and bariatric surgeons for stomach stapling/gastric bypass. (What is harder to pin down is what the operation will cost you and/or your insurance carrier, as Elizabeth Rosenthal, a physician-turned-journalist and New York Times reporter, made shockingly clear in her 2013 series about the cost of healthcare in America.) Multiple studies, in many of the surgical subspecialties, have documented that some operations being performed today for specific diseases have outcomes no better than nonsurgical treatment. For instance, a randomized study out of Norway published in the journal *Spine* in 2003 compared lumbar spinal fusion to physical therapy in the treatment of chronic low back pain and disc degeneration. The study found no difference in pain outcomes between the two methods of treatment. The only obvious difference was the much higher cost of the spinal fusion surgery. According to the Agency for Healthcare Research and Quality, over a ten-year period (2001-2010) the number of spinal fusion operations nearly doubled to 465,000 at a cost of \$12.8 billion in 2011. None of this is new information, and most surgeons are aware of such studies within their own specialty. Why, then, do these operations continue? They constitute a physical cost to the patient, as well as a financial cost to the system. Maybe surgeons are performing these operations because they truly believe they can help people, despite what the data shows. Maybe some are performing these operations because they feel subtle pressure from the political environment they practice in or the hospital system they work for. Perhaps the surgeon feels pressure to earn a guaranteed salary, meet quarterly benchmarks, keep patients in the community, and prevent leakage to other hospitals. The question that must be answered is this: Are these potentially unnecessary operations being performed for purely economic reasons? Like every profession, surgery is not exempt from bad seeds. As difficult as it is to write this, some surgeons operate for solely economic reasons. You've read about them in the news. There was the neurosurgeon operating out of an Oregon hospital who was discovered to be performing unnecessary spinal fusion operations (a very expensive procedure) for economic reward from 2008 to 2011. He ultimately had his license suspended and faced multiple patient lawsuits. There was the cardiologist from Baltimore who, in 2009, was placing cardiac stents in patients at a clip well beyond what most cardiologists report doing. He billed Medicare over \$6 million over several years. There was the orthopedic surgeon from New York who pleaded guilty to ten federal counts of Medicare/Medicaid billing fraud while performing sham operations. These well-publicized cases of rogue surgeons who were operating purely for economic reasons, completely unconcerned about the harm they were causing patients, are shocking. They are also, I'm glad to say, rare. Recent changes in Medicare rules that are intended to improve payment transparency may help uncover more instances of fraudulent billing and unnecessary operations. A recent federal ruling removing a decades-old court injunction that prevented public access to Medicare billing information is changing the landscape, and for the better. Since 1979, the vast library of individual physicians billing to Medicare had been hidden from view. With the Affordable Care Act, signed into law in 2010, that all changed. The thinking is that by shining the light of day on

physicians (especially surgeons) Medicare billing habits, the proclivity of some who are performing too many of one specific operation (compared to their colleagues) will send up a red flag. This kind of information (particularly if outcomes are persistently bad) could also be a fraud alert, as well as an indication of the quality and experience of individual surgeons. Medicare audits are exactly how some of the preceding examples of unnecessary surgery were initially discovered. While some in medicine are opposed to this trend, I believe Medicare claims billing transparency will be a helpful tool in weeding out surgeons who are in this profession for money rather than love, profiting and performing unnecessary operations on unsuspecting patients. The greed and abuse is not restricted to surgical procedures. Other medical literature is finding data showing that patients are undergoing nonsurgical procedures they may not need. These procedures were not necessarily performed out of purely false intent but also out of a liability fear of missing something, or based on a different interpretation of existing medical guidelines. A recent study out of the University of Texas published in JAMA found that close to 23 percent of colonoscopies for twenty-four thousand Medicare patients age seventy and older were inappropriate based on the U.S. Preventive Services Task Force guidelines for screening colonoscopy. For individuals over age seventy-six, that number increased to 39 percent. The rates of inappropriate testing varied widely by physician. And some of the patients stated they would not trust a doctor who did not recommend the procedure, further complicating the motivation behind the numbers. Medicare reimburses physicians approximately \$260 per colonoscopy, while private insurance reimbursement approaches \$350 per case. (Reimbursement for colonoscopy was once more than \$1,000 per case.) As the author of the JAMA article stated, Any time you have a fee-for-service system, there is a risk in over-utilizing services that get well-reimbursed for the time spent to perform them.