

# SPECIAL REPORT UNION OF AMERICAN PHYSICIANS & DENTISTS

## An Interview with Stanford A. Marcus, M.D.

BY SIMSON L. GARFINKEL

*Dr. Stanford A. Marcus is a retired surgeon and President of the Union of American Physicians and Dentists, who believe that fee-for-service medicine should be abolished in the United States and replaced by a system in which every physician is paid an annual wage based on experience and social worth.*

### What is your union?

We are the Union of American Physicians and Dentists. We are a registered trade union, registered with the U.S. Department of Labor, and have been in business since April 18, 1972. We operate in 13 states. Our numerical base is mostly [in the Western part of the country].

### Who are your members?

They are physicians in all practice settings: fee for service, government service, salaried by organizations such as [health maintenance organizations], and insurance companies. They are all practicing physicians.

### How many members do you have?

Forty-eight thousand nationally.

You have a proposal to revamp the way that health care is paid for in this country. What is it?

Actually, it's not as grandiose as that. I don't feel that I'm competent enough to make a whole new system of health care. What has been decided is that there will be a whole new system of health care [in this country], and that the financing and distribution of this will differ diametrically from what existed up until 10 years or so ago.

**"As a doctor gains experience, increasing his value to society, his salary should reflect an approach to that of Larry Bird more than that of a freshman congressman."**

My concern is with the role of the physician as the ultimate hands-on provider of health care, and as the designated responsible party who gets sued when things go wrong.

[Physicians] find themselves in an awkward catch-22 position. As they undergo this drastic transformation from small entrepreneurs, in what was essentially a cottage industry, into impersonal providers in a new, large corporate or government enterprise, the role of the physician is being redefined, much to the pain of practicing doctors.

There are essentially two things that doctors want and need in order to keep up their motivation. One is the autonomy of professional decision making, if you will, that enables them to maintain the pride that has brought them up to the present time.

The other is a purely socioeconomic

consideration, where they are not so ground down and devalued, both financially and in their status in society.

### What do you mean by that?

I think that there has been a great tendency to minimize the fact that when the chips are down, it is not the insurance company or Department of Health and Human Services or any of their other functionaries who operates to make sick people well—it is still the doctor. The buck stops on the desk of the doctor. . . . [Yet] the doctor is no longer free to say what treatment can be administered, how many units of service can be rendered, where the service can be rendered, and how much will be paid for the service.

Do you mean that all of these decisions are being made for the physician?

That's right—or, indeed, whether the payment will be even be made at all. Sometimes there are demands for repayment for treatment that was rendered in good faith. Subsequent review by some other, uninvolved party actually compels repayment of money that was legitimately earned.

### How often does that happen?

Frequently. This is not to say that there are not some crooks in medicine. We make no representation that we are saints, but we think that our ethical conduct is higher than the average member of Congress. We don't see why we should be singled out for this new sort of denigration.

### What do you propose to do?

I think that rather than scrambling for coins, as we are presently doing in the death throes of our fee-for-service system, and going through the indignity of the American Society of Internal Medicine, for example, trying to outscramble the surgeons, and somebody else trying to outscramble the primary-care physicians. I think that a decent socioeconomic worth for doctors ought to be determined.

### By whom?

By whomever is imposing this system on us. Increasingly, this is government, represented by legislatures and courts, and the health-insurance industry, which has reached the stage of becoming a shameful cartel, and all of the other people who are scrambling to get their hands on a piece of what they consider to be the lucrative health business.

I don't want doctors to have to be economic players in this, except to assert that we have a worth—somewhere on the scale between that of day laborers and Larry Bird of the Boston Celtics.

We want to be able to negotiate our worth at a bargaining table, on the basis

of terms that people can understand. . . . But we can't even start the negotiating process while we are fighting to see if we can get an extra 50 cents for an electroencephalogram. . . . Those minuscule considerations are pure cost and have nothing to do with quality of care.

I think that when we graduate as doctors, we probably should start from



STANFORD A. MARCUS, M.D.  
President, Union of  
American Physicians  
and Dentists

a level playing field. We think that the initial worth of a doctor, turned loose in the marketplace, is roughly equivalent of a freshman congressman. So a starting salary should be in the neighborhood of \$87,000. As [a doctor] gains experience, increasing his value to society, his salary should reflect an approach to that of Larry Bird more than that of the freshman congressman.

This will liberate doctors from this terrible little game they are playing of marketing, and running ads in the yellow pages, and tying in sales of test and office dispensed medications, and that sort of thing.

### Who would pay this wage?

Whoever presently pays for it. Doctors who until recently have received 18 cents of the national health-care dollar should not be ground down to smaller and smaller percentages but probably should get a more realistic percentage of that dollar.

An example: a physician finishes his internship and sets up a one-man practice in a small town in the Midwest. Who is going to pay him \$87,000 a year?

The answer, of course, is that the involvement of the state and federal government is coming. . . . Massachusetts already has a paid system of state-

sponsored health care; the federal government has several bills introduced; the state of California has several bills introduced into its legislature. Even the august *New England Journal of Medicine* has proclaimed that nationalized health insurance is an idea whose time has come.

I don't think that there is any dispute that we are on the brink of a totally new system of financing. I am merely saying that the system should not be established on the basis of the erroneous impression that you can continue to pay for it out of the only compressible segment of health care, which is the earnings of the physician.

Everything else reaches its irreducible minimum: You cut down on hospital payments enough and a hospital will close—it's happening every day. You can deny health care to enough people, [until people start fighting back, when they] realize that their mother might have lived a few years longer had the system not pulled the plug on her, so to speak.

But I don't want doctors to be the rationers: our job is to make people well. We are not gods to proclaim who should live and who should die. We just work to ease suffering, and [help people] who want to live a little longer.

Do you feel that it is more appropriate for physicians to set the wages of physicians than other people?

Yes. Let's put it this way: there was a time when a worker had nothing to say about his wage, hours, or working conditions, and it led to such exploitation—sweat shops and child labor—that the country was forced to rise up and, out of simple fair play, enact a series of labor laws to give the worker some sort of equitable representation and negotiating input.

Now I am not, under any sense, representing doctors as being a downtrodden minority. [But under the fee-for-service system] our union represents doctors who have been denied due-process rights that are customarily granted to ax murderers: the right to be judged by their peers; the right to be advised of the charges against them in advance of a kangaroo court; the right to a transcript of a hearing; the right to be represented by an attorney; the right to cross-examine their accusers.

You would think that those things would be automatic, but they are specifically being denied to doctors. Those are the things that we fight against as a union.

Are we saying, "Should doctors determine their own wage?" The answer is "no." But all of life is transactions, all of life is negotiation.

Please turn to page 39

Sept 89  
15-

# PHYSICIANS' MARKETPLACE

nearby. Service area 500,000 plus. Will remain till September to introduce. Phone (915) 542-3336.

**WELL ESTABLISHED.** solo practice in Internal Medicine in Las Vegas, Nevada. I can retire when I find someone to take care of long time loyal patients. Please write: C.J. Kilduff, M.D., 2100 Maryland Parkway, Las Vegas, Nevada 89104 or call (702) 735-2434.

**WIS. UNOPPOSED ALLERGY**

**PRACTICE.** Thriving practice in growing city of 50,000 in metropolitan area of 800,000. Major educational, cultural, recreational facilities. Gross over \$300,000. Will introduce. Allergy SC, 217 Wisconsin, Waukesha, WI 53186

## ORGANIZATIONS

**PRICE** is an organization whose goal is to facilitate communication

of research efforts, clinical observations, and practice innovations among physicians involved in cost-effective medical care. Interested physicians may gain membership by submitting a letter of interest and a c.v. Contact David J. Shulkin, M.D., Physicians for Research in Cost Efficiency, 926 Bellefont St., Pittsburgh, Pa 15232

**CARDIZEM SR**  
(diltiazem HCl) sustained release capsules  
For hypertension

## CONTINUING EDUCATION

**TUTORIAL COURSES OF INSTRUCTION IN ACUTE CARDIAC CARE.** University of Miami School of Medicine, Miami, Florida. Dates of courses: SEPT. 18-23, 1989; OCT 16-21, 1989; DEC 4-9, 1989; JAN 22-27, 1990; FEB 26-MAR 3, 1990; APRIL 16-21, 1990; MAY 21-26, 1990. Contact: Louis Lemberg, M.D.

University of Miami School of Medicine, Division of Cardiology (D-39), P.O. Box 016960, Miami, FL 33101. (305) 549-6411

## PUBLICATIONS

**INTERNISTS:** Review medicine in an enjoyable manner using mnemonics. Improve recall of journal articles and textbook material. Write Harbinger Medical Press, PO Box 17201, Winston-Salem, NC 27116 for catalog of publications.

tions.  
**CARDIZEM'S**  
(diltiazem HCl) sustained release capsules  
For hypertension

**INTERNAL MEDICINE WORLD REPORT**

## Physicians' Union

Continued from page 3

In the 17 years of our existence, we have gotten back over \$100 million from insurance companies [and other institutions responsible for funding medical services]. Within the past year, we have gotten back \$17 million from the state of California, and \$9 million from the city and county of San Francisco, for the doctors that we work for, in addition to standing up to the Blue Cross/Blue Shield outfits who have made it fun and games not to pay doctors.

We're not a bunch of rich doctors trying to get richer. I'm living in a split level home in a suburb that looks like Levittown. I have never aspired to drive a chain of Mercedes or have a country home on the south shore of France. But I think that what I do should be worth more socially than what an awful lot of people get paid handsomely for. Bit by bit, they have negotiated their worth upward: no forum has been established for us to have any input into the determination of the worth of what we do.

I have been a general surgeon throughout my career. I have been a very unique general surgeon: I have felt strongly that the imbalance in earnings of the cognitive specialties that has evolved has been something that has come about by happenstance and opportunity, rather than by the actual value of individual practitioners to society. So while I don't think that we all ought to be paid exactly the same, under some sort of monolithic system, I think that we all should start out at the same starting gate and have the same opportunity to advance ourselves, as in some sort of civil-service system.

I could never see the logic of a cardiac surgeon making three-quarters of a million dollars per year and a pediatrician working his tail off in a ghetto office for perhaps \$55,000 a year. That will be redressed. But it should not be redressed in a game of take-away against each other, because then we will be turned into a bickering group of individuals on the basis of nothing but self-interest. We should be freed up to do our best, and be paid handsomely, on a wage schedule that enables us to concentrate on getting sick people well, rather than on beating out the other specialties or the other practitioners.



**Sectral**  
acebutolol HCl  
For uncomplicated control of PVCs.

(Brief summary of prescribing information)

**CONTRAINDICATIONS:** SECTRAL is contraindicated in: 1) persistently severe bradycardia; 2) second- and third-degree heart block; 3) overt cardiac failure; and 4) cardiogenic shock. (See WARNINGS) **WARNINGS:** Sudden death has been reported in patients with a history of heart failure who are controlled with digitalis and/or diuretics. Both digitalis and SECTRAL impair AV conduction. If cardiac failure persists, therapy with SECTRAL should be withdrawn in PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE. In patients with aortic or mitral valve disease or compromised ventricular function, continued depression of the myocardium with  $\beta$ -blocking agents over a period of time may lead to cardiac failure. At the first signs of failure, patients should be digitalized and/or given a diuretic and the response observed closely. If cardiac failure continues despite adequate digitalization and/or diuretic, SECTRAL therapy should be withdrawn.

**EXACERBATION OF ISCHEMIC HEART DISEASE FOLLOWING ABRUPT WITHDRAWAL:** Following abrupt cessation of therapy with certain  $\beta$ -adrenergic receptor blockade impairs the ability of the heart to respond to  $\beta$ -adrenergic mediated reflex stimuli. While this might be of benefit in preventing arrhythmic response, the risk of excessive myocardial depression during general anesthesia may be enhanced and difficulty in restarting and maintaining the heartbeat has been reported with beta-blockers. If treatment is continued, particular care should be taken when using anesthetic agents which depress the myocardium, such as ether, cyclopropane and halothane, and the lowest possible dose of SECTRAL should be used. SECTRAL, like other  $\beta$ -blockers, is a competitive inhibitor of  $\beta$ -receptor agonists and its effect on the heart can be reversed by cautious administration of such agents (e.g., dobutamine or isoproterenol—see INDICATIONS). Manifestations of excessive vagal tone (e.g., profound bradycardia, hypotension) may be corrected with atropine 1 to 3 mg i.v. in divided doses.

**DIABETES AND HYPOGLYCEMIA:**  $\beta$ -blockers may potentiate insulin-induced hypoglycemia and mask some of its manifestations such as tachycardia; however, dizziness and sweating are usually not significantly affected. Diabetic patients should be warned of the possibility of masked hypoglycemia.

**THYROTOXICOSIS:**  $\beta$ -adrenergic blockade may mask certain clinical signs (tachycardia) of hyperthyroidism. Abrupt withdrawal of  $\beta$ -blockade may precipitate a thyroid storm, therefore, patients suspected of developing thyrotoxicosis from whom SECTRAL therapy is to be withdrawn should be monitored closely.

**PRECAUTIONS: IMPAIRED RENAL OR HEPATIC FUNCTION:** Studies on the effect of acebutolol in patients with renal insufficiency have not been performed in the U.S. Foreign published experience shows that acebutolol has been used successfully in chronic renal insufficiency. Acebutolol is excreted through the GI tract. But the active metabolite, diacetolol, is eliminated predominantly by the kidney. There is a linear relationship between renal clearance and diacetolol and creatinine clearance. Therefore, the daily dose of acebutolol should be reduced by 50% when the creatinine clearance is less than 50 mL/min and by 75% when it is less than 25 mL/min. SECTRAL should be used cautiously in patients with impaired hepatic function.

SECTRAL has been used successfully and without problems in elderly patients in the U.S. clinical trials without specific adjustment of dosage. However, elderly patients may require lower maintenance doses because of the bi-phasic nature of both SECTRAL and its metabolite are approximately doubled in this age group.

**CLINICAL LABORATORY FINDINGS:** SECTRAL, like other  $\beta$ -blockers, has been associated with bradycardia and may present a false-positive electrocardiogram (ECG). Exaggerated hypotensive response has been reported from the combined use of  $\beta$ -adrenergic antagonists and a-adrenergic stimulants contained in proprietary cold remedies and vasoconstrictive nasal drops. Patients receiving  $\beta$ -blockers should be warned of this potential hazard. No significant interactions with digoxin, hydrochlorothiazide, hydralazine, sulfhydryl, oral contraceptives, tobutamide or warfarin have been observed.

**CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** Chronic oral toxicity studies in rats and mice employing dose levels as high as 300 mg/kg/day which is equivalent to 15 times the maximum recommended (60 kg) human dose, did not indicate a carcinogenic potential for SECTRAL (acebutolol HCl). Diacetolol, the major metabolite of SECTRAL, was without carcinogenic potential in rats when tested at doses as high as 1800 mg/kg/day. SECTRAL and diacetolol were also shown to be devoid of mutagenic potential in the Ames Test. SECTRAL, administered orally to two generations of male and female rats at doses of 240 mg/kg/day [equivalent to 12 times the maximum recommended therapeutic dose in 60 kg man] and diacetolol, administered to two generations of male and female rats at doses of up to 1000 mg/kg/day, had no significant impact on reproductive performance or feminin-TERATOGENIC EFFECTS. Pregnancy Category B. Reproduction studies have been performed with SECTRAL in rats and rabbits at doses of up to 60 mg/kg/day, the equivalent to the maximum recommended therapeutic dose in a 60 kg man. Studies have also been performed in these species with diacetolol (at doses of up to 450 mg/kg/day in rabbits and up to 1800 mg/kg/day in rats). Other than a significant elevation in postimplantation loss with mg/kg/day diacetolol, a level at which food consumption and body weight gain was reduced in dams, and a non-statistically significant increase in incidence of bilateral cataract in fetuses from dams treated with 1800 mg/kg/day diacetolol, there was no evidence of harm to the fetus with either drug. There are no adequate and well-controlled trials in pregnant women in the U.S. However, studies have shown that both acebutolol and diacetolol cross the placenta. Because animal teratology studies are not always predictive of the human response, SECT should be used during pregnancy only if the potential benefit justifies the risk to the fetus. Labor and Delivery: The effect of SECTRAL on labor and delivery in pregnant women is unknown. Studies in animals have not shown any effect of SECTRAL on the usual course of labor and delivery.

**Nursing Mothers:** Acebutolol and diacetolol also appear in breast milk with a milk:plasma ratio of 7:1 and 12:2, respectively. Use in nursing mothers is not recommended.

**Pediatric Use:** Safety and effectiveness in children have not been established.

Adverse Reactions: SECTRAL is well tolerated in properly selected patients. Most adverse reactions have been mild, not required discontinuation of therapy, and tended to decrease duration of treatment increases.

The following table shows the frequency of treatment-related side effects derived from controlled clinical trials in patients with hypertension, angina pectoris, and arrhythmia. The patients received SECTRAL, propranolol, or hydrochlorothiazide as monotherapy, or place

Body System/ Adverse Reaction	TOTAL VOLUNTEERED AND ELICITED (U.S. STUDIES)			Placebo (N=31) %
	SECTRAL (N=102) %	Propranolol (N=42) %	Hydrochlorothiazide (N=173) %	
Cardiovascular				
Chest Pain	2	4	4	1
Edema	2	2	4	1
Central Nervous System				
Depression	2	1	3	1
Dizziness	6	7	12	2
Fatigue	6	9	13	4
Headache	6	9	13	4
Insomnia	3	8	5	1
Abnormal Innervation	2	3	0	1
Dermatologic	2	2	4	1
Rash				
Gastrointestinal				
Constipation	4	2	7	0
Nausea/retching	4	5	5	1
Dyspepsia	4	6	7	1
Flatulence	3	4	7	1
Nausea	4	6	3	0
Gastroenteric Mucintention (frequency)	3	1	9	<1
Respiratory				
Atthralgia	2	1	3	2
Myalgia	2	1	4	0
Cough	1	1	2	0
Dyspnea	4	6	4	2
Rhinitis	2	2	4	<1
Special Senses				
Abnormal Vision	2	2	3	0

The following selected (potentially important) side effects were seen in up to 2% of SECTRAL patients: Cardiovascular: hypotension, bradycardia, Central Nervous System anxiety, hyper/hyposthesia, impotence. Dermatologic: pruritus. Gastrointestinal: vomiting, abdominal pain. Genitourinary: dysuria, nocturia. Musculoskeletal: back pain, joint pain. Respiratory: pharyngitis, wheezing. Special Senses: conjunctivitis, dry eye, eye pain. The incidence of drug-related adverse effects (volunteered and elicited) according to SECTRAL dose is shown below. (Data from 268 hypertensive patients treated for 3 months; a constant dose)

Body System	400 mg/ day (N=132)	800 mg/ day (N=43)	1200 mg/ day (N=71)
	Cardiovascular	5%	2%
Gastrointestinal	3%	3%	7%
Musculoskeletal	2%	3%	4%
Central Nervous System			
Respiratory	1%	13%	17%
Skin	1%	5%	6%
Skin	2%	2%	2%
Special Senses	2%	2%	6%
Genitourinary	2%	3%	1%

**POTENTIAL ADVERSE EFFECTS:** In addition, certain adverse effects not listed above have been reported with other  $\beta$ -blocking agents and should also be considered as potential adverse effects of SECTRAL.

**Central Nervous System:** Reversible mental depression progressing to cataplexis (an acute syndrome characterized by disorientation for time and place), short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance (neuropsychometrics).

**Cardiovascular:** Intentional of AV block (see CONTRAINDICATIONS). Atrial: Erythematous rash, fever combined with aching and sore throat; laryngospasm, an respiratory distress.

**Hematologic:** Agranulocytosis, non-thrombocytopenic, and thrombocytopenic purpura. Gastrointestinal: Mesenteric arterial thrombosis and ischemic colitis.

**Musculoskeletal:** Reversible alopecia and Peyronie's disease. The oculomucocutaneous syndrome associated with the  $\beta$ -blocker practolol has not been reported with SECTRAL. See investigational use and extensive foreign clinical experience.

**Keep at room temperature. Approximately 25°C (77°F).**  
SECTRAL is not indicated in ventricular tachycardia.

**References:**  
1 Shapiro W, Park J, Koon GQ. Variability of spontaneous and exercise-induced ventricular arrhythmias in the absence and presence of treatment with acebutolol or quinidine. Am J Cardiol 1982;49:445-454.  
2 Chondrosarats PAJ. Comparison of acebutolol with propranolol, quinidine, and placebo. Results of three multicenter arrhythmia trials. Am Heart J 1988;106:138-150.

**WYETH-AYERST LABORATORIES**  
Pharmaceutical Division  
Philadelphia, PA 19101