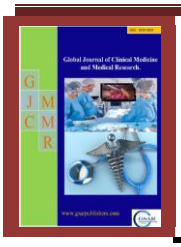

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Regaining Public Trust in Physicians

BY

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Abstract

Patients in many countries have lost faith in medical care providers, especially physicians. Reasons for current mistrust include lack of choice, affordability, depersonalization, accessibility, outcomes, CoViD experience, and frustration with healthcare systems.

Government control of health care denies patients' their medical autonomy and prevents the proper, fiduciary patient-doctor relationship. The only way trust and fiduciary connections can be restored is by taking medical and financial decision-making authority away from third parties and returning control to patients.

INTRODUCTION

Polls in the U.S. and elsewhere report that people no longer trust their doctors. [1] Additional evidence of mistrust includes escalating violence against healthcare workers, worsening doctor and nurse burnout, and accelerating erosion of clinical workforce, [2-6] even as the nonclinical, bureaucratic healthcare workforce expands. [7]

Restoring trust starts with knowing why it was lost. After identifying the etiology of *patient* Healthcare's symptoms, the public may regain trust with restoration of the fiduciary patient-doctor connection that has been severed.

This report will focus first on the U.S. and then consider the status of trust in single payer nations such as Great Britain, Canada, and Australia.

Patient-Doctor relationship

By custom and law, patients have medical autonomy, i.e., ultimate authority over medical decisions that directly impact them. [8] The fiduciary connection in healthcare involves a voluntary relationship where a patient yields his or her medical autonomy temporarily to a specific chosen care professional who uses that power exclusively for the patient's benefit. It is based on the patient paying an amount agreed upon by both parties, analogous to contracting with a lawyer for a fee known in advance. If someone other than a fiduciary surgeon took a scalpel to a patient, that would be attempted homicide.

In the U.S. and single payer systems, third parties – government or insurance – have sole autonomy. They make both medical and financial care decisions. The patient gets care when, where, by whom, and even if, decided by a bureaucrat not by the patient. Third party decision making effectively abrogates patients' medical autonomy. [9].

Third parties also decide what physicians (sellers in market terms) are paid. The connection is not voluntary for either party, and neither patient nor physician makes decisions regarding care or payment. Thus, third-party structure nullifies any true fiduciary relationship. [10].

The lack of the proper fiduciary patient-doctor relationship is at the core of why patients no longer trust doctors.

Reasons for mistrust in U.S.

Reasons for mistrust of physicians include lack of choice, affordability, depersonalization, accessibility, outcomes, CoViD (with loss of medical autonomy [11]), and system frustration.

Lack of choice

Americans don't trust their doctors because they are not *their* doctors! Patients don't choose their physicians – third parties do. Physicians are assigned to patients by unaccountable government or health plan bureaucrats from panels of doctors acquired *en bloc* through low-bid contracts.

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Patients cannot trust caregivers forced on them by some nameless, faceless third party. Absent voluntary choice by patient and doctor, there is no fiduciary relationship.

Affordability

With prices such as the following, very few individuals can afford to pay for care out of personal funds: $2850 for an MRI, $1000 for a vial of insulin, $5000-$10,000 per day in an ICU, $10,000 per month for dialysis, or a six-figure bill for major orthopedic, neuro-, or open-heart surgery. Paying such charges is impossible for 99 percent of the population and patients blame physicians.

The public believes doctors are responsible for unaffordable high costs with their exorbitant salaries, ordering unnecessary tests and procedures, [12] and constructing elaborate fraudulent schemes.

Some clinicians do order medically unnecessary tests, usually to protect themselves from lawsuits. For example, to minimize liability risk, ER physicians will order a head scan when someone hits his head falling off a bicycle even without loss of consciousness to have objective proof of absence of intracranial hemorrhage. Physicians make no personal profit from ordering these tests.

While MD fraud makes good headlines, such schemes are rare. [13]

What patients see as exorbitant prices are actually *charges*. They assume, as in any free market transaction, that price equals charge which is the amount paid. This is not true, Patients do not see actually *payment*, typically a small fraction of charges. This author's charge for a cardiac catheterization in a critically ill baby ranged from $2500 to $9000 depending on devices used or implanted. Medicaid paid maximum "allowable reimbursement," $367.

Patients cannot trust physicians who appear to be overcharging them and making care unaffordable.

Patients do not understand where healthcare dollars go, believing most healthcare spending, $4.3 trillion in the U.S. in 2022, goes to doctors, hospitals, and pharmacies. In fact, approximately two trillion of these expended "healthcare" dollars, nearly half of all U.S. healthcare spending, goes to government and insurance BARRCOME (bureaucracy, administration, rules, regulations, compliance, oversight, mandates, enforcement), *not to care*! [14, 15]

Depersonalization

Patients complain bitterly as follows. *My doctor doesn't know me as an individual. My doctor spends more time staring at the computer than looking at me. How can I trust a doctor who doesn't even know my name, much less what I need medically or what I am allergic to?*

Such complaints of depersonalization are valid. However, assigning blame to physicians is misplaced. Between the enormous government regulatory burden and time-consuming hospital and insurance administrative obligations, physicians have little-to-no time to talk to, examine, or simply *be with* patients.

When commercial management principles are applied to healthcare, they can sometimes impair quality of care. Care providers are supposed to be efficient. Efficiency refers to the number of units produced or manipulated per unit of time. The more pencils, automobiles, sweaters, or widgets a worker makes in an eight-hour shift, the more efficient he or she is. The efficient physician sees the most patients in a day, meaning he or she spends the least time with each patient.

Patients are not widgets. Caregivers need to be *effective*, not merely efficient. One patient may need only fifteen minutes to be satisfied with the therapeutic episode while another may need two hours or more.

Physicians receive scorecards based in part on their ability to achieve an efficiency benchmark. For example, as set by my university faculty practice plan, this author's benchmark was to *care for* 4.2 established patients per hour, i.e., 14.5 minutes per patient. As a pediatric cardiologist, this is ludicrous. It often required 15 minutes of playing with a child before he or she would trust me enough to allow a physical exam.

When patients complain they are being rushed through the office, they should blame the system, not the caregivers.

Accessibility

Lack of access is another compelling reason for distrust of physicians. *What good is being assigned a physician if I can't get in to see him or her?*

Before the Affordable Care Act (ACA, 2010), maximum wait time to see a primary care physician was already a medically unconscionable 99 days. [16] After implementation of the ACA, wait time had increased to 122 days, causing death-by-queue, dying while waiting in line for care. [17]

Long wait times are another valid source of public frustration and distrust. However, Americans' ire should be aimed at the responsible parties, Washington, and insurance companies. Long wait times are related to the combination of low "allowable reimbursements" (payments), delays in payments sometimes for years, time-wasting bureaucratic complexity, and the drive to be efficient. The last encourages doctors to have long lists of patients on their panels making it harder and harder to get an appointment.

This author's family physician had a list of more than 900 patients. After my wife began complaining of abdominal pain, it took seven months to get an appointment. The diagnosis was inoperable pancreatic cancer. One wonders whether it was inoperable seven months earlier.

The seesaw effect contributes to distrust of physicians. [18] Medicaid is a no-charge-to-patient government-provided insurance program that was initially intended as a medical safety net limited to "Old-Age, Survivors, and the Disability Insurance Program." [19] After five decades of incremental expansion of the program, 92 million Americans, 28 percent of population, are now enrolled in Medicaid.

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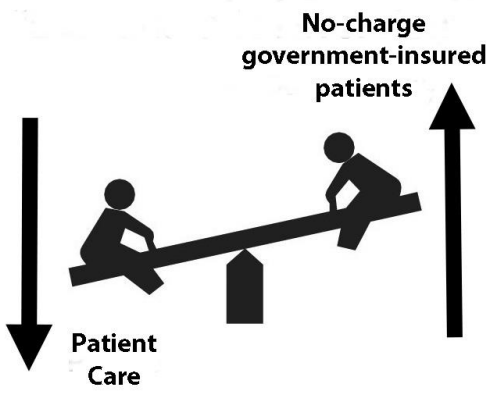
As more people are covered by Medicaid, they reasonably expect to get care. After all, they now have insurance. However, with the increase in bureaucratic spending associated with all government programs, government payments to physicians go down, often below doctors' cost of doing business. To pay for ACA bureaucracy with its further expansion of Medicaid enrollment, Washington took $716 billion out of Medicare funds, intended to pay for care. When low payments are added to overwhelming BARRCOME hassle with its time-devouring demands, more and more doctors decline to accept government-insured patients for care. [16, 20-22]

Figure 1: The Seesaw Effect in Healthcare



The seesaw effect is as follows. [18] As the number of patients expecting, in fact demanding, timely care *goes up*, and the number of physicians available to them declines, access to care *goes down*. Patients who can't get the care they were promised, distrust physicians.

Outcomes

The U.S. is reported to have inferior health outcomes, viz., longevity, infant mortality, and complications of diabetes, when compared to other nations. [23] The public blames physicians.

The metrics noted above have very little to do with physician activities. Longevity is influenced mainly by genetics and lifestyle. Some of the longest-living people on earth live in primitive conditions of the Hunza Valley of northern Pakistan where there is minimal healthcare and no local doctors [24]

High infant mortality is often related to illicit drug usage, which is epidemic in the U.S. Furthermore, different countries have different ways to measure infant mortality. Some like the U.S. count all live births while others count only likely survivable births, thus excluding extreme low birth weight babies or those with severe congenital malformations.

America is the most obese populous nation on earth. This leads to high incidence of type 2 diabetes in the population with associated medical complications. The U.S. population is 41.9 percent obese and has average human longevity of 76.4 years. Japanese live an average of 84.5 years and have an obesity rate of 4.3 percent (see Worlddata.info.)

CoViD experience

The U.S. CoViD experience contributed to Americans' distrust of physicians. President Biden and corrupt Anthony Fauci [25-27] blamed those who refused the jab for creating a "pandemic of the unvaccinated." [28] Flip-flopping and counter-intuitive recommendations exacerbated confusion and distrust such as facemasks were unnecessary, then required, then two were better than one, and assuredly effective despite scientific evidence they don't protect against CoViD contagion. [29] After being labelled misinformation, reports of adverse effects contrary to the official Washington narrative were suppressed. [30, 31] Bureaucrat MDs prohibited practicing MDs from treating patients with effective drugs such as Ivermectin. [32]

Americans resent and resist government tyranny such as CoViD lockdowns and mandatory injections with experimental mRNA gene therapy, so-called CoViD vaccines, that did not have appropriate testing for safety and quality control. [33-35]

Washington's mandatory responses to the CoViD "big con" that they created [10] destroyed what little public trust remained in the medical establishment.

System frustration

Americans are exceedingly frustrated with their healthcare system, which is impossibly complex, contradictory, and constantly changing. It is so convoluted that Affordable Care Act of 2010 (called Obamacare by former President Obama) had to create a whole new category of healthcare bureaucrats: navigators. Patients cannot take out their frustration on an amorphous system. They are angry at and distrustful of the people they hold responsible: doctors.

American physicians (and nurses) are at least as frustrated as patients. The system tells them what they can and cannot do for patients negating their use of good medical judgment. Washington imposes a one-size-fits-all approach, mandates a huge regulatory burden, thereby denying clinicians the psychic reward they studied and worked for years to acquire. [36] Such frustration with the system is expressed as anger which can be (mis)perceived by patients as anger toward them. This magnifies patients' distrust and can create a positive feedback loop.

Single-payer systems -

United States

The U.S. is not usually listed as single-payer healthcare. [37] The common thread in all single payers is the government, not the individual, being responsible for medical as well as financial decisions. [38] In market terms, government controls both supply and demand. Single payers-use central economic planning, similar to the Soviet Union.

In the U.S., Washington directly controls medical decisions and personal expenditures for Medicaid, Children's Health Insurance Program, Medicare, and Tricare enrollees. These 167 million Americans clearly have single-payer healthcare.

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Approximately 140 million Americans have employer-supported private insurance. The "employer support" is tax-advantaged compensation the employee does not receive. Employer pays this money to insurance companies that expend the money as they see fit consistent with benefits requirements established by federal regulations and rules. Insurance companies negotiate contracts for payments based on federal allowable reimbursement schedules for Medicare and Medicaid. Thus, Washington indirectly controls medical and financial decisions for privately insured individuals. They too have single-payer healthcare, just camouflaged.

The average American family will expend $32, 065 on healthcare in 2023. [39] More than 80 percent of *their spending* goes directly from employer to insurance company. For the majority who are healthy, more than $25,000 of family money will be expended this year without their consent for no demonstrable gain to them.

For uninsured Americans, there is health care via the unfunded mandate established by Emergency Medical Transport and Labor Act of 1986. This Act requires hospitals to provide medical care when individuals present themselves at a federally funded hospital emergency room even if the hospital will not be paid for care provided. All U.S. hospitals receive federal funds via Medicaid, CHIP, or Medicare, and therefore the Act applies to all. The number of uninsured, estimated at 26 million in 2022, is a constantly moving target because of the recent huge influx of illegal immigrants exacerbated by states such as California that allow illegals to enroll in Medicaid. The cost of care for these persons born by taxpayers is unknown.

The U.S. is an unrecognized single-payer system.

Single payers in general

Since single payers are centrally controlled economically – free market forces are absent – dollar-inefficient spending, i.e., on BARRCOME, will inevitably be high.

In a 1999 study of healthcare spending comparing the U.S. with Canada, Woolhandler et al reported that "administration," a catchphrase for BARRCOME, accounted for 16.7 percent of Canadian expenditures on healthcare while the U.S. spent nearly double, 31.0 percent. [40] In absolute dollar amounts, the U.S. spends nearly twice what Canada spends on its healthcare system. Thus, BARRCOME consumption of "healthcare" dollars – spending that produces no care – is similar in both nations.

The well-worn doctor joke, "I have good news and bad news," applies to single-payer systems. The good news is that single payers spend considerably less than the U.S. [41] The bad news is how they do it.

To save money, single payers employ medical rationing. [42] They have insufficient numbers of nurses and doctors, too few facilities, and severe limitations on miracle drugs and devices. Single payers can not provide either the quality or the timeliness of care that patients need and expect. The end result is death-by-queue, [43] a phrase coined for people covered by the NHS who die while waiting in line – in Great Britain, a queue – for care.

That is why people in single payers are distrustful of the system and its ostensible agents, doctors.

Great Britain

Great Britain's National Health System (NHS) is considered a paradigm single-payer system. For many decades, the NHS apparently enjoyed public support. As NHS was established in 1948, the vast majority of the British population have known only single-payer healthcare.

In recent years, Britons have become disenchanted and increasingly dissatisfied and distrustful of the NHS. [44] Access is an increasing problem, e.g., when the NHS canceled 50,000 surgeries for lack of staff and/or facilities. [45] Substandard outcomes in NHS hospitals has been an ongoing dilemma for years. [46, 47] The NHS even had a program, the Liverpool Care Protocol, that paid bonuses to doctors who euthanized patients. [48] This was discontinued in 2014 after a public outcry.

Another issue is personal medical autonomy, which the NHS rejects. Both NHS regulations and British law state that the ultimate arbiter of life and death is the government, not the individual. [49]

Doctors, just like patients, have been unhappy with the NHS single-payer system. The first MD strike occurred in 2016. [50] The exodus of senior, experienced physicians from the NHS has now reached crisis levels. [51] This is a grave problem not only for current patients but for future patients as the NHS is losing the experienced physicians necessary to train future generations of doctors.

Between its staffing issues, quality concerns, limited access, and financial woes, former British Health Minister warned of collapse of the vaunted NHS. [52]

Canada

Through the use of medical rationing, Canada spends roughly half of what the U.S. spends on its healthcare system. [40] Comparison of health outcomes in Canada versus the U.S. shows extreme delays in care resulting in potentially avoidable deaths – so-called death-by-queue – in Canada as well as the U.S. [53]

Where Great Britain has regional Trusts overseeing healthcare, Canada's Provincial governments are in charge with their borders. There are minor differences in rules and regulations between the provinces but effectively, they are similar to Great Britain with the same problems in staffing, lack of medical autonomy, delayed access, and insufficient facilities. [54-59]

Australia

Australia's single-payer took the concept of medical tyranny, [11] with its abrogation of medical autonomy and personal freedom, to a whole new level. In 2021, the Morrison government established internment, "quarantine" camps for

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those infected with COVID or suspected of contact with those having a positive COVID test. [60]

Other nations

In most developed nations, government plays a major, usually dominant, role in healthcare. Hybrid single-payer systems in China, Denmark, Germany, Greece, Hong Kong, Israel, Italy, Japan, Singapore, Spain, Taiwan, etc., all face similar problems to the countries discussed herein.

Conclusion

Wherever government controls healthcare, people no longer have faith in either their doctors or their healthcare systems, for all the reasons elucidated above.

The root cause of mistrust and the reason why healthcare systems fail to deliver affordable, timely, compassionate care is third-party – government and/or insurance – decision-making, both financial and medical. Only when medical autonomy as well as control of spending are returned where they belong, to We The People, only then will the public regain trust in physicians and in healthcare.

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