Doing and thinking: a view from the operating room

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YEARS AGO, when life was perhaps simpler, the medical profession was to a great extent divided into groups of "doers" and "thinkers": surgeons and nonsurgeons. During the past two decades, however, this distinction has become increasingly blurred, and in no specialty has this change been greater than in the field of cardiology. The cardiologist of old relied on his stethoscope and his ability to interpret electrocardiograms and x-rays, but now he may perform cardiac catheterizations or angioplasties, insert intra-aortic balloons and pacemakers, or prescribe streptokinase in addition to interpreting echocardiographic and radionuclide studies.

To a surgeon looking across the professional scene at his cardiologic colleagues this change elicits mixed feelings. For years cardiologists have accused surgeons, sometimes in jest and sometimes seriously, of being interested only in operating. On the other hand, surgeons now see cardiologists who want to spend all their time in the laboratory doing invasive studies and who openly express their dislike for seeing patients in the office and their pleasure in technical accomplishments. There is nothing wrong with this attitude provided the implications of being a "doer" are recognized.

First, "doers" must be appropriately trained. Current cardiology training may be falling short in this regard. Training in technical operating skills, the discipline of the operating room, and the analysis of morbidity and mortality and the discussion of technical errors, which are an essential part of the training of a surgeon, might be incorporated into that of the invasive cardiologist. An active rotation on a surgical service could enable the fellow to learn technical skills and gain a valuable visual knowledge of pathology, which is essential for the surgeon and equally important for cardiologists doing angioplasties and interpreting arteriograms.

Second, the cardiologist who becomes a "doer" should subject himself to the control of a "thinker." However much cardiac surgeons complain about cardiologists — and they do — the relationship between them has created an appropriate balance with both ethical and commercial implications.

In the United States doctors are paid more for "doing" than for "thinking." Fees for procedures are high. Fees for opinions are low. It is therefore not unnatural that as new procedures have been developed, cardiologists have wanted to confine performance of them to members of their own specialty. Surgeons do not behave otherwise. But this leads, and perhaps has already led, to an increasingly uncontrolled situation. A single cardiologist, for instance, could obtain a history and perform a physical examination, interpret an electrocardiogram and an echocardiogram, prescribe streptokinase, do a first catheterization for diagnosis, a second catheterization for an angioplasty, order Holter monitoring and a second echocardiographic examination, interpret radionuclide studies, insert first a temporary and then a permanent pacemaker, and follow the patient in the hospital for 2 weeks with daily visits. He might then refer the patient to a rehabilitation program that he owns and runs. For all these services and visits an individual fee may be charged without referral of any part of the care to another physician. The temptations, whether conscious or not, are obvious.

What are possible solutions to these problems? Training in cardiology should provide more formal opportunities for developing surgical skills for those technically inclined. Manual skills take a long time to perfect, and are seldom learned casually. After writing recently to the directors of about 15 cardiology training programs I found that formal experience in pacemaker insertion is offered in only half the programs. Yet many of the graduates of these programs will find themselves in a position in which they will want to insert pacemakers, which they will do after very limited training and on-the-job experience.

The danger of uncontrolled self-referral for lucrative procedures is a real one in all branches of medicine.
For surgeons these problems have been partly solved by a referral system in which there is control of the number and type of patients seen and by remuneration in the form of one fee for total care, an accepted practice that preceded implementation of DRGs (diagnostic related groupings) by decades. In those parts of the profession in which “doing” has become an important and essential part of care a similar system should be introduced based on a fair estimate of time involved, complexity of procedures, dangers to the patient, and skills required. In this way the tendency, and the temptation (to which surgeons are by no means immune) to charge for every procedure, even though each is an integral and essential part of management, is avoided.

There is much to be said for separating ourselves into “doers” and “thinkers,” and it is still not too late for cardiologists to separate themselves into distinct and unconnected groups of physicians practicing invasive and noninvasive medicine. In the long run, however, a system of remuneration should be devised in which we get paid less for “doing” and more for “thinking.” Fees are seldom reduced as time goes by, and fees for new procedures are almost always higher than those for older, more established procedures, even though they may not be more difficult. The fees for inserting pacemakers, for example, were set in an era when it was necessary to do a thoracotomy. The fees have not gone down although the procedure is now technically much simpler and less risky.

The tide of the times is such that cardiologists will almost certainly be doing more, rather than fewer, procedures in the future because of their primary positions in making decisions about the care of patients and because many of the newer procedures are not technically demanding enough to be regarded as operations. Surgeons, because of their experience as “doers,” are well aware of the satisfactions, pleasures, temptations, frustrations, and sorrows associated with their actions and technical endeavors. Perhaps now is the time to realert our cardiologic colleagues to the professional pitfalls towards which they appear to be heading with accelerating speed.
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