UNDER MY SKIN

Demotion (With Apologies to Franz Kafka)

As Dr. Gregory Samplingerror awoke one morning, he found that he had been demoted overnight to a ridiculous second-tier physician.

"I cannot go to the office," he thought. "All the patients will see the change in me at once. And even if they don't, they will realize it when they find their copayment is $10 more."

Gregory called his new secretary, Ms. W, and told her to close his schedule indefinitely, as something had come up. He could tell that Ms. W knew the reason.

BY ALAN ROCKOFF, M.D.

Gregory unfolded the official notice. "You have been assigned to Tier Two," it read. "You have been tiered at the customer service unit [CSU] group level, according to your LCU/CSU."

"This must be some mistake," thought Gregory as he showered and dressed. He chose a charcoal gray suit, dark blue tie, black trench coat, and bowler—attire befitting a Tier One physician. "I will straighten things out at once by contacting my LCU Medical Director, as instructed," he said. "But first I must learn what an LCU is."

Pulling up his collar and drawing his bowler down over his eyes, Gregory set out for an unfamiliar district. Rows of gray apartment blocks lined both sides of the street. Unemployed men in shirtsleeves idled on balconies, toasting marshmallows. A young woman took Gregory's arm. "I see you are lost," she said, handing him a marshmallow. "The local care unit is there," she said, "third floor." Then she was gone.

On the third landing, a uniformed guard leafed through a dog-eared ICD-9 manual. He eyed Gregory with a sardonic smile.

"I must see the director," said Gregory. "By some mistake, I have been …"

"Designated Tier Two," said the guard, with a show of indifference. "The director is out," he added.

"When will he return?" asked Gregory.

"Afterward, possibly," said the guard, offering Gregory a chair.

Three months later, Gregory asked, "Is there someone else I can see about this?"

"The deputy director is in," said the guard, "but I warn you that he can do nothing. However, you may suit yourself. Third office on the right."

Eager to be heard at last, Gregory hurried to the office near the end of the corridor, where he found the deputy director at his desk, wearing a green eyeshade, smoking a fine Havana cigar. "Please come in," he said, "but I cannot help you."

"Why have I been designated Tier Two?" asked Gregory.

"Our clinical performance improvement initiative," said the deputy director, "incorporates principles agreed upon by local or national stakeholder groups. ETG methodology was used as the basis for efficiency analysis. Please take off your hat."

"What is an ETG?" asked Gregory.

"Episode Treatment Group," said the deputy director. "It measures your quality and efficiency compared to those of your peers in treating episodes. These measures have been validated by RHI, HEDIS, and AHRQ. Cigar?"

Gregory declined. "Can you tell me what I've done wrong?" he asked.

"No," said the deputy director. "The director might be able to, but he is out. In any case, he takes directives from the Group Insurance Commission, which has mandated quality measures. Our job is merely to implement their mandate."

"Where is their office?" asked Gregory.

"They don't have one," the deputy director said. "And now, if you'll please excuse me . . ."

"But wait," said Gregory, who was beginning to grow alarmed. "Why has the GIC done this?"

The deputy director aimed a contemplative puff across his desk. "To address rising health care costs and reduced employer coverage, the GIC has demanded incentives for consumers to make more informed choices about health care options and for providers to examine their practices relative to their use of resources compared to their peers."

"Is it clear that consumers will change doctors to save $10 on a copayment?" asked Gregory.

"Not yet," said the deputy director. "However, we have identified a problem and taken a proactive step."

"But how can I rise to Tier One," said Gregory, "when I don't know what I did to sink into Tier Two?"

"For one thing," snapped the deputy director, "you could improve your relative score! Look at this!" he demanded, brandishing a sheet of white paper. "A q-score of 1.3! A resource utilization score of 1.16! Outlying performance on ETG 675, 'Fungal skin infection w/o major surgery'! Disgraceful! If we labeled you Tier One, how could we justify our fiduciary stance to our stakeholders?"

"Do the stakeholders have an office?" asked Gregory, who was trembling now. "I can explain …"

"They have no office," said the deputy director, ushering Gregory to the door and handing him his bowler. "They are outside, holding the stakes."

Gregory stumbled down the stairs, the laughter of the guard and deputy director ringing in his ears. Outside, barefoot children mocked him. "Tier Two, Tier Two!" they jeered. A pair of impassive, shirt-sleeved men Gregory recognized from the balcony approached with sharp, pointed sticks. Each took him by one arm. "Who are you?" asked Gregory. "We are the stakeholders," said one. "But where are we going?" asked Gregory. "To toast marshmallows," said the other.

"And you, Dr. Gregory Samplingerror," said the other, "are the marshmallow." ■

DR. ROCKOFF *practices dermatology in Brookline, Mass. To respond to this column, write Dr. Rockoff at our editorial offices or e-mail him at sknews@elsevier.com.*

GUEST EDITORIAL

Why Should We Value Cosmetic Surgery?

Although almost anyone who reads magazines, surfs the Web, or watches TV knows that cosmetic surgery is a growth industry that has spawned intense competition for prospective patients, most are probably unaware of the schism created within plastic surgery over this area of practice. Here's my view of what has happened over the years.

BY WILLIAM M. KUZON JR., M.D.

In generations long past, most plastic surgeons performed a mix of cosmetic and reconstructive procedures, with reconstructive surgery being perceived as the core mission of the specialty. Plastic surgeons were almost always on hospital staff, took call at hospitals, and performed most of their procedures in hospital-based operating rooms.

Beginning in the 1970s and accelerating in the 1980s, as reconstructive surgical technology rapidly advanced, procedures became long, work intensive, and arduous. Insurance reimbursement for these services failed to keep pace with the true cost—personal and professional—of the procedures. As a result, many plastic surgeons increased their volume of aesthetic cases.

At the outset, I believe, plastic surgeons frequently viewed this trend as a way to pay the bills while still performing reconstructive surgery. Although they continued to do reconstructive work in hospitals, many began to build luxurious office suites and free-standing operating rooms that allowed them to cater to cosmetic surgery patients. Those who remained on hospital staffs or with academic centers bore a proportionately larger workload of reconstructive cases, sometimes causing them to give up aesthetic surgery altogether.

Today, residents commonly arrange to set up an independent office facility; some of them never apply for hospital privileges. What was once a relatively homogenous specialty has split into two discrete groups of surgeons that view themselves as either primarily cosmetic or reconstructive. These camps come into conflict on many levels, notably over the use of collective resources to advance the specialty's financial and academic interests.

The American Society of Plastic Surgeons has done a remarkable job of supporting both reconstructive and aesthetic surgeons, recently enacting a fundamental change in governance that will enhance the service, educational, and research agendas for plastic surgery. Nevertheless, the fact that major actions have been taken and the issue continues to be an agenda item for our specialty is an indication of how wide the gap has grown.

While watching this evolution, I have been struck by the fact that most physicians, most surgeons, and even many plastic surgeons cannot give me a cogent answer to this question: Why should aesthetic surgery be valued by medical schools, by large medical centers, by the Centers for Medicare and Medicaid Services (which, by the way, pays the salaries of residents in multiple specialties as they learn to do cosmetic procedures), and by the entire medical enterprise?

Think about it. What's your answer?

Here's mine: Aesthetic surgery is the ultimate reconstructive surgical challenge.

To undertake a cosmetic procedure, a surgeon must have the enormity of ego, and the skills to support it, to believe that "normal" can be made "better" (which is, by the way, the official definition of cosmetic surgery). One must have a keen eye for surface anatomy and for aesthetics, be maniacally sure about every detail of the surgical procedure, and be almost insanely attentive to the patient's psyche.

To fulfill the mission of restoring form and function to afflicted patients, plastic surgeons must continually strive for technical virtuosity and aesthetic perfection. The end result is that the skills learned in aesthetic surgery pay enormous dividends for reconstructive patients on a continual basis.

In other words, cosmetic surgery makes reconstructive surgery better.

That's why, regardless of how schizophrenic it seems or how challenging it is, I believe that reconstructive surgery and aesthetic surgery must remain conjoined as the specialty that is plastic surgery. More important, I believe that's why the medical enterprise should value aesthetic surgery. ■

DR. KUZON *is professor of plastic surgery at the University of Michigan, Ann Arbor.*