VII
A Commercial Note

"Riches and honor are what men desire; but if they attain to them by improper means, they should not continue to hold them." —Confucius, *Sayings*

Clinical laboratories have progressed from the home-manufactory stage to modern automated assembly line techniques. As in industry in general, each new machine represents an outlay of capital that must be recouped, but it also leads to a lessening of the man-hours needed for finished products. Furthermore, the number of highly trained (and hence expensive) operatives is reduced; the new techniques can be taught quickly to the equivalent of semiskilled workmen. A conventional twelve-test blood chemistry profile thus may cost less than five dollars—and even less in large laboratories. Automation, therefore, can give more and more services at lower and lower costs to the consumer, in this case, the patient.

It can but does it? Dr. Herbert Lansky, past president of the New York State Society of Pathologists, has said that doctors contracting with large laboratories have not passed on the low cost to their patients. Dr. E. G. Shelley, reporting for the American Medical Association Judicial Council, describes one bill sent to a patient: "Serology, $7.50; cholesterol, $7.50; alkaline phosphatase, $7.50; complete blood count, $12; sedimentation rate, $6; glucose, $5; urea, $7.50; uric acid, $7.50." All these tests were done for a charge of $6 to the physician. For an outlay of $6 the doctor got $60.50. Not a bad markup, huh?

The College of American Pathologists denied in February, 1969 that it tried to cut down competition and keep prices high, but it agreed, nevertheless, to a consent decree rather than fight an antitrust suit. Senator Philip Hart, in February, 1970, chairman of a Senate Antitrust and Monopoly subcommittee, reported that his staff found that a quarter of a billion dollars could be saved annually by reducing the fees paid to hospital pathologists for unneeded but mandatory token supervision. (Mandatory—by state laws and the Joint Committee on Accreditation of Hospitals. Who would dare accuse such honest men as our legislators and our top doctors of having no sense? It's more charitable to say they are in collusion.) A common method of paying hospital pathologists is by a percentage of the gross laboratory charges, 9.5% of which are for routine work which the pathologist did not order, perform, interpret or record. The pathologists say that a laboratory test without interpretation is worthless. They are right, but one wonders whether the cost of that interpretation is not set at what the traffic will bear. (Besides, they don't interpret the tests. The attending physician does—if and when he does.)

It is now possible for doctors to enter into contracts with commercial laboratories for a flat fee ranging from $75 to $300 a month. Such a contract entitles the doctor to an unlimited number of tests for any number of patients. Naturally he passes on the cost of the service to his patients, just as he passes on the cost of bandages or hypodermic needles. Unfortunately, two temptations arise, one mindless and one mercenary. Because the cost is so little the doctor may order tests indiscriminately, with the expected consequences: the level of informational noise is raised; the doctor is lulled into a sense of complacency that he is giving good medical care; and the patient is deluded into thinking that laboratory tests are essential for diagnosis and treatment. The second temptation is yielded to too often. The doctor, by charging his patients "for laboratory tests," can make a very good profit on a service which was originally intended as a help to him. Such overcharging exists, enough to bring about complaints to medical societies, threats by insurers to refuse payments, and warnings of governmental action.

The Judicial Council of the American Medical Association has clearly stated its position: let the patient pay the laboratory for his tests; let the doctor be the interpreter of those tests. Thus the suspicion of markups or commissions will be avoided and the doctor will not be tempted to be a profiteer. The statement sidesteps the issue. It looks backward to the time when tests were "handmade" for each patient and doesn't take cognizance of the new contractual laboratory arrangements.

Considering that the public spends three billion dollars each year for laboratory work, the question of fees is not trivial. Who is to benefit from the advance in technology—the patient by lower costs or the doctor by increased income?