Health Reform – What do the doctors think?

Confused by the current debate, some have posed the above question. Nobody knows. Few of us pretend even to know the question. Physicians reason in a manner missing from the ongoing discussion.

Like the public at large, we reactively opine (often with diverse opinions) regarding the consequences of this or that proposal for payment, insurance, or delivery changes but we are also aware of the Cat's admonition to Alice ..."it doesn't matter" if, like Alice, you ..."don't much care where" you are going.

Physicians know where they are going. They serve to maintain or improve the health status of each unique patient and community as effectively and efficiently as possible. They have little idea whether this is the goal of health reform.

About 30 years ago, with the help of an excellent physician assistant, for a two week period I served as the sole physician practitioner for a three physician station (hospital, clinic, obstetrics, detoxification unit) in rural South Dakota. It was the first time I worked with such a paraprofessional and I was amazed at his knowledge and proficiency. Initially, I was perplexed regarding when he sought my assistance and when he did not. To me, the severity or complexity of the patient's condition did not seem to be the determining factor.

After several days, the answer became evident. We thought differently. I approached each patient and situation as a unique *inductive* exercise to gain and weigh a great diversity of historical and current facts, symptoms and signs, e.g., social, biological, cultural, demographic, physical, genetic, behavioral, to narrow and establish a diagnostic condition and initiate appropriate therapy. He approached each patient as potentially a sufferer of one or more of a number of common diagnostic conditions and *deductively* applied an evidenced based protocol when he established a "match". He needed my help when he could not identify a match.

Today's health reform debate has identified a plethora of diagnostic conditions and evidenced based protocols. For each, different experts and politicians aver they have established the answer, i.e., "match", applicable to every individual and community. However, there is massive disagreement regarding which match and protocol is universally valid, applicable and of highest relative priority. Physicians *deductively* will weigh in on the right match and protocol for each condition but this is answering the wrong question.

What if we ask a different question? Suppose we ask each physician to assess the health status of his or her unique patient and community populations and *inductively* narrow down and select the conditions that most influence the maintenance and improvement of health status, prioritizing actions that would most effectively and efficiently assist to achieve this goal. That is how we train physicians to think. If we aggregate the results, we will know what the doctors really think.

About a year ago, an Associated Press article asserted that based upon the findings of a Commonwealth Fund report, decreasing by 50% the number of adults currently uninsured in

West Virginian would elevate the health status of the population to one of the highest in the Nation. I could count on one hand the number of physicians who believed that assertion.

If queried as to the percentage of the population that presents in emergencies rooms with far advanced disease primarily because of *economic* inability to access timely preventive and primary care, I would predict the number would be very low. West Virginia has a vast network of health departments, primary care clinics, and critical access hospitals that provide such care based upon one's ability to pay.

Most physicians support universal access to timely care but I would predict that a sizeable majority would agree that enhanced insurance coverage will not lead to significant health status gains. I would hypothesize the majority would, instead, identify a number of social, cultural, geographical, educational, and behavioral factors (violence, substance abuse, high-risk pregnancy, diet, obesity, inactivity, dementia and mental conditions), that contribute to poor health status, as well as various local/regional organizational impediments that decrease how effectively and efficiently a patient can successfully navigate the patient care process. Suggestions regarding the most successful actions to maintain and elevate health status likely will involve addressing these concerns within each community – and possibly further biomedical research breakthroughs and automation.

Some reform proposals acknowledge these issues and actually propose new or enhanced "top down" programs and funding to address them but it is not clear if – or how – local communities would actually be empowered and motivated to address *their* priority issues. Usually such programs require a community to conduct activities someone else has determined are of high priority, not the community's per se. Furthermore, some proposals increase support for training of certain categories of personnel, e.g., public health physicians, without any clear idea of how local communities would employ and afford such personnel.

Perhaps before we rush forward to reform health care we should ask the doctors what they think. However, to do so we must define the overriding goal, i.e., improved health status, more clearly articulate the major provisions (and locus of implementation responsibility for each) and solicit/ aggregate the *inductive* opinion of each physician regarding the impact such changes would have collectively upon the health status of his or her patient and community populations.

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