

Health reform bill will not contain costs - The Solution (Part 1 of 2)

Historically, physicians –respecting the autonomy of each individual to direct his or her own destiny - focused on maintaining and improving the health status of their patients, not providing services. Patients, the public and policy makers aver physicians should continue – or refocus – on doing so. In reality, many initiatives over the last few decades (including the current reform proposal) promote the opposite.

Traditionally, a patient and physician essentially entered into an unwritten contract whereby the physician incurred a legal and ethical obligation to care for the patient, until the physician formally “discharged” the patient or the patient retained a different physician. This relationship was based upon a mutually shared goal and duties to maintain the health status of the patient. When either party believed the pursuit of this mutual goal was being compromised, they were free to terminate the contract in an orderly manner. In the case of physicians, discharge usually involved the physician’s belief that the patient was not responsibly incorporating the behavioral and treatment recommendation he or she recommended.

Usually few problems developed since the patient chose a physician he or she believed – in approach and demeanor- would be responsive to their health status goals and most physicians had a healthy respect for – and were able to accommodate – the autonomy of each individual. Most medical care was relatively inexpensive and, compared to today, there was relatively little physicians could do to maintain their patient’s health status. Most importantly, only two parties governed the term and tenure of the contract.

In the last 50 years there have been drastic changes in the physician-patient relationship. Exponential expansion in environmental and biomedical sciences, have markedly increased what both the patient and physician (as well as the community at large, e.g., sanitation) can do to maintain the patient’s health status. Many of these options are expensive. A “team”, clinic or multiple health care practitioners and institutions, rather than a single physician, are often responsible for the care of a patient, which introduces formidable challenges to provide care compatibility, coordination and continuity.

Numerous other entities dictate - or attempt to influence - the conduct of both the patient and physician (e.g., government, employer, insurance company), often through assuming the primary responsibility of “reimbursing” the physician(s) for the care provided. Advocacy and commercial interests through greatly enhanced communication modalities and techniques directly appeal to patients and the public to embrace their products and approaches. This can result in patients suggesting or insisting a physician employ treatment options he or she does not believe are in the patient’s best interest. The contractual relationship between a doctor and patient has been greatly muddied.

For those individuals unable or unwilling to self-direct and coordinate their health care in light of the increased complexity, various strategies (organizational integration, e.g., “medical home”, automation and integration of health information, patient advocates) are being explored to assist. These hold promise as long as the patient is actively engaged in promoting their health status, enrolled in a participating medical practice and the care network is broad enough, e.g., public health, social service, transportation, to include all important clinical and support services. This requires local communities (not just individual institutions and practitioners) to be empowered and actively involved in the process. Few are. The reform legislation does little to create local community incentives, mechanisms and authorities to promote this end. That must change.

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