

# Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

Editor-in-Chief: *David B. Nash, MD, MBA* • Managing Editor: *Janice L. Clarke, RN, BBA* • Editorial Staff: *Deborah C. Meiris, Alexis Skoufalos, EdD*

## Health Care Reform: “Uhhhh, Do We Have to Include the Patients?”

By *Samuel Lin, MD, PhD, MBA, MS*

Today’s patients have become more sophisticated in the ways and means of health care. They expect to be included in medical decision making that impacts them or their family members. This transformation from passive recipients to assertive associates in health care has come about primarily because of advances in medical tenets and information technology rather than as a consequence of concerted endeavors by the health care establishment to empower patients or to nurture their health care capacities and competencies.

Historically, the provision of health care services has been based upon a sequential logic of illness or injury followed by curative or reparative treatment. Also, the authority and decisions about patients’ health care processes have been managed within the purview and determination of the physician. Thus, it was inevitable that patients would perceive health status and medical treatment as mystical phenomena, the secrets and conduct of which were known, indisputably, only to the physician. Medicine’s forefathers and insightful sages - from Hippocrates to Oliver Wendell Holmes and beyond - promulgated this sentiment in their day.

As a consequence of the foregoing, a mantle of omniscience and infallibility

was bestowed upon the physician that left little need or incentive for patients to learn about or assume any obligation for their health care. Thus, the lack of lay health knowledge and the fear of the unknown led patients to relinquish ownership of, and involvement in, addressing personal health concerns.

Another unfortunate sequela was that the parochial nature of health care, exhibited only by curing and repairing (ie, paying for encounters rather than prevention or outcomes), contributed readily to an explosive growth in direct costs (eg, diagnoses, therapies) and indirect costs (eg, loss of wages, overall societal productivity). Further, these costs escalated because uninformed, unmotivated patients allowed illnesses to progress beyond their more readily treatable states and sought care only in more advanced stages of disease when poorer prognoses require more expensive, prolonged treatments. One promulgation of this disposition led to the current burgeoning and costly use of the emergency department as the alternative norm to regular primary care.

Fortunately, the advent of several seemingly distinct phenomena encouraged a realignment of the conventional medical wisdom

governing health care, and also provided sound pathways to reduce health care costs.

First, in the late 1970s, the sentiment for health promotion and disease prevention rose to national prominence as an alternative to the staid doctrines of only curing and repairing.<sup>1</sup> The premise was that practitioners and patients could improve their lot in health status and related fiscal outlays by adopting a culture of reducing disease through proven interventions of preventive health practices and modified lifestyle regimens.

Second, in the mid-1980s, a notion emerged and proliferated that positive consequences of health interventions and therapies could be standardized and ordained by employing effective and economically sound evidence-based best practices.<sup>2</sup> Such practices would contribute to enhancing medical care in 2 ways: (1) by incorporating newly-defined objectives (eg, health status, quality of life, comparative costs, patients’ informed opinions) into the clinical decision-making processes, and (2) by facilitating documentation, measurement, and assessment in common databases.

Third, in the early 1990s, the rapidly growing age of information technology incorporated health knowledge. Thus,

*(continued on page 2)*

health information technology (HIT) became an accessible commodity and utility for all persons, from practitioners to patients. This cyberworld phenomenon was particularly instrumental in advancing the ability of patients to search for health information and become more inquisitive regarding their physicians' decisions. If knowledge is a necessary root of power, patients now were becoming astute power brokers and partners in the construct of their health care.<sup>3</sup>

The stem principles of these 3 seemingly distinct phenomena represented potential solutions for enhancing active versus passive patient care, access, quality care, and meaningful outcomes while ameliorating rising costs. Furthermore, these determinants engendered themselves as new critical dimensions for health care (ie, patient participation, value-based care, treatment choices). Preventive measures that promote optimal health status require informed patient participation in health behavior modifications including lifestyle, diet, exercise, environment, and regular attention to health care. In contrast, the conventional sentiment of only curing or repairing allows little forethought for advancing preventive assessments, predictive algorithms, and developing alternatives to standardized treatment modalities.

The quantifiable protocols for assessing health outcomes, effectiveness, and efficiencies substantiate the management and reduction of health care risks as indisputable justifications for health promotion and disease prevention.

This accession of health economic and outcomes assessments also leads to a rethinking of traditional measures of dependent variables that resulted in either successful or failed therapies.

With public access to HIT through the media and the Internet, patients are able to savor their long-desired roles as comanagers of their own health care. And as part of their becoming informed "customers," patients also can obtain comparative information on practitioners, treatments, costs, and alternative modalities. In essence, the health care that they are now engaging in as owners and partners can become more transparent.<sup>4,5</sup>

As stated previously, the advancement of patients into the management of their own health care processes cannot be credited to any concerted effort of the health establishment. This poignant observation is critical for practitioners to appreciate if they are to establish progressive linkages in the patient-physician partnership. Such a relationship equates to a patient-physician parity in decision making but does not imply equivalency in clinical competencies or judgements. Thus, while the patient can learn and discern the essentials about the extant disease process, the advanced clinical knowledge and practice skills needed to ultimately care for the patient remain appropriately within the purview of the physician.

In any case, this new participatory role for patients, embodied as full partners and owners of their personal

medical decision making, must be endorsed and advocated by physicians if the new order of health care reform is to be propagated equitably. Lastly, these new-found ingredients for patients, including health knowledge, information technology, reduced treatment variables, and a greater informed adherence to clinical protocols, will contribute progressively to more prudent spending that leads to reduced outlays of health care costs as the ultimate measure of true health care reform.

*"Physicians will be called on to develop a new partnership with a public that is more responsible for its own care."*

Jerome P. Kassirer<sup>6</sup>

*Samuel Lin, MD, PhD, MBA, MS, is a former Assistant Surgeon General and retired Deputy Assistant Secretary for Health in the US Department of Health and Human Services. He can be reached at: sam.lin@comcast.net.*

## References

1. US Department of Health and Human Services. *Healthy People*. Washington, DC: US Government Printing Office; 1979:5.
2. Jaeschke R, Singer J, Guyatt G. Measurements of health status. Ascertaining the minimal clinically important difference. *Control Clin Trials*. 1989;10:407-415.
3. Slack WV. The patient's right to decide. *Lancet*. 1977;2(8031):240.
4. Crawshaw R, Rogers DE, Pellegrino ED, et al. Patient-physician covenant. *JAMA*. 1995;273:1553.
5. Wennberg JE. Outcomes research, cost containment, and the fear of health care rationing. *N Engl J Med*. 1990;323:1202-1204.
6. Kassirer JP. Patients, physicians, and the Internet. *Health Aff (Millwood)*. 2000;19:115-123.