DORLAND'S PEOPLE AWARDS LUNCHEON

October 4, 2010, National Press Club, Washington, DC

KEYNOTE SPEECH

Personal Medical Care
More Than Individual Or Herd Care

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I really appreciate the opportunity to speak today at the Dorland Health People Awards Luncheon.

A focus on individual patients and their care is much needed in a health system that now concentrates more on a disease and its technological treatment than it does on the care of the person with the disease. The People Awards addresses this disparity by appropriately recognizing those who deliver outstanding patient care rather than those who limit themselves to the cure of disease, often ignoring the patient.

This focus on the patient is particularly important as an introduction to a summit on health care coordination, as the use of technology in the treatment of disease could become the primary focus of care coordination, leaving the patient a secondary consideration. The patient with the disease, not just the disease, must be the origin and center of coordinated care.

Regarding the patient as the center of care is not new. Over 2400 years ago, Hippocrates, the Father of Medicine, noted that it's far more important to know what person has the disease than what disease the person has.

A century ago, Sir William Osler, the iconic Johns Hopkins Medical School professor, said "The good physician treats the disease; the great physician treats the patient who has the disease."

And as Professor Frances Peabody of Harvard Medical School put it in 1925, "…the secret of the care of the patient is caring for the patient."

Today, many do not agree with Osler and Peabody. They regard medical care merely as the applied science of statistically derived, evidence-based medicine. This is treatment based upon the majority of a group. It is based on a herd.

Herd medicine treats individuals as statistical integers and makes truly personal care, almost impossible.

Medical care is still referred to as "the practice of medicine." As Osler put it, *"The practice of medicine is an art, based on science."* Essentially, this is care that is individualized.

But medical care should be more than individualized. Care should be personal. Individualized care defines a person in terms of the sum of measureable characteristics such as *age, height, weight, blood pressure, blood chemistry, and genetic makeup*, just to name a few.

Personal medical care includes not only these characteristics but also those characteristics that are more difficult to measure such as *cultural background, education, training, vocation, likes and dislikes, a personal view of health and disease and other biases.*

These have a strong impact upon the effectiveness of disease management. They are neglected in herd care and often neglected in individualized care.

I want to emphasize that traditional *personal* medical care should not be confused with the recently advocated *personalized* medical care that uses genetic markers to target care methods. This genome based care alone may provide more precise care, but it is no more *personal* than a fingerprint.

Since I started medical practice just after WWII, the trend toward depersonalizing medical care has been particularly evident. What medical science has accomplished since then is absolutely stunning – and it's only the beginning.

But it has come at a cost. First, there is the real dollar cost. Technological care does not come cheap. Second, our social compassion has extended these benefits to more and more people, gradually making medical care an entitlement, which compounds this cost. And lastly, people have removed themselves from allocating, that is, rationing their own medical dollar. They have turned their medical purse and decision-making over to a third party, an insurance entity or the government. These entities determine how to spend that dollar based upon the needs of a group, the herd, not necessarily based upon the needs of the person.

As a consequence, in the attempt to control the rising costs of medical care, the focus of care has shifted to the use of technology in the treatment of diseases. This shift has come at the expense of personal care and the general well-being of the patient, in part by victimizing the primary care practitioners, who traditionally have been the ones mainly responsible for delivering compassionate, personal care.

These are changes I have personally observed since medical school in the practice of medicine for 60 years delivering personal-care as a Board Certified internist and cardiologist in several parts of the country, and as a member of various medical organizations, including advisory groups to Blue Shield and Medicare. I have anecdotally detailed these changes, and my interpretation of their causes and

consequences, in my book *Time To Care: Personal Medicine in the Age of Technology.*

When I was a child, Medical care was primarily a family matter. Visits to doctors were restricted to very serious complaints. My mother had two large volumes dedicated to home health care remedies. I had my share of iodine gargles, mentholatum chest rubs, chamomile tea, and cod liver oil. Somehow, I was spared the springtime castor oil purge. Until my teens, the only time I went to a doctor was for a dog bite. Our doctor made 3 to 4 house calls for fevers with rashes.

Hospitals were few and distant in rural areas. One of my medical school preceptors in Northern Wisconsin told me of kitchen table surgery he had done in his early days of practice. Babies were delivered at home, even in the big cities. I was one of them in Chicago. Many had no Emergency Departments, or Emergency Rooms as they were called in the few hospitals that had them in the cities.

In the mid-1930s, my dad took me to visit my mother and new baby brother in a Milwaukee Hospital after 8:00 pm. The hospital doors were locked and unattended. We got in through a service entrance off an alley.

As late as the 1980s some elderly people were frightened and resisted recommended hospital care. They remembered that a hospital was where relatives and friends went and died.

Financial responsibility for medical care accrued to the patients. Payment of doctors was out-of-pocket, or occasionally in rural communities with produce.

Up until the mid-century, only a minority of people had medical insurance. My dad had it through his insurance company job in the late 1930s, when I was hospitalized for bilateral hernia surgery. Of the 16 days there, I was kept bedfast for 12 days. It took me a week to walk erect. It cost my dad $9.00 out of pocket.

Blue Cross was started largely in the 1930s and 1940s, often by radiologists, pathologists, and surgeons. During WWII, many jobs started to provide employees with medical insurance. It helped maintain the war effort and control inflation when more money than goods was available.

Medical insurance only covered in-hospital charges, in-patient diagnostic procedures, and surgeons' fees.

As hospital insurance was too expensive for most people, more affordable fear-based insurance coverage of specific diseases such as poliomyelitis, stroke, or cancer was promoted.

With the introduction of Medicare and Medicaid in the mid-1960s, private insurance expanded to cover most out-patient as well as in-patient services.

At the time, legislators had no idea as to how much office, clinic and inpatient charity care was given by doctors and hospitals, nor did they seem to care. Initial wariness of Medicare by doctors and patients in the first several years was replaced by enthusiasm. Now providers were being paid for what had been charity work. More extensive, private insurance coverage was offered then for out-patient services as well as in-patient care.

The flood gates were open. Medical inflation soared. The impact of Medicare on hospitals was considerable. Cost control resulted in the elimination of clinics and nursing schools. Certificates of Need became a requirement for major changes. After 1984, the impact of Medicare's diagnosis-related groups, reduced lengths of stay.

Further cost-control measures decreased doctors' out-patient service reimbursement. This had unintended, unappreciated, and adverse consequences for

patients of primary care doctors. Doctors could not afford to devote the time needed for personal care. Volume, not quality, of care, became the watchword.

As patients became increasingly dissatisfied with being treated as a number and seeing their doctors for only a few minutes, they started going directly to the more expensive specialist of their choice without a doctor's referral. And doctors started referring more patients in order to reduce their work load and liability.

Although 48 % of specialists deliver some primary care, they have no time either, even if inclined, to provide reassuring personal care. They provide the more highly remunerative diagnostic or therapeutic procedure that often is unnecessary.

One of my 82-year-old patients went directly to a large orthopedic group for her first episode of acute osteoarthritis of the knee. Knee replacement surgery was canceled three times that spring. She decided to wait until after the summer to reschedule. She never needed the replacement. Her occasional symptoms were controlled with Tylenol.

With less reassuring personal care by a trusted primary caregiver, people have become more litigious, too, another reducible expense.

Another effect of reimbursement reduction for cognitive care, that is, the personal interaction between doctor and patient, was that many primary care practitioners learned to do income supplementing procedures, such as sigmoidoscopies they had been referring to other doctors.

This did not prove to be an adequate financial remedy. And more importantly, it was not enough to change perceptions of medical students, as most were graduating with large debts. They saw that the average income of primary care physicians was lower than specialists'.

Consequently, medical students became less interested in primary care, intending to become specialists. In the past 10 years, their interest in primary care has dropped from near 50% to 12%. . An increasing number of these become hospitalists who do not take care of outpatients but restrict their practice to the technical care of in-patients. .

As a consequence of these formidable economic forces, the primary or personal care doctor is becoming an endangered species who is less valued. This is in part cultural, as our society becomes more technology oriented.

Occasionally on explaining to a new cardiac patient why he had to change various health habits, he would interrupt with, “Hey, Doc, don’t bother me with my disease, just cure me?” Most patients like this go directly to a surgeon, looking for an easy technologically based cure.

Now, instead of the family medical guidebook like my mother used, people go to the internet for their medical information. There were 160 million medical web searches last year. Patients often bypass the generalist and the specialist they select may be the incorrect one.

Since the 1980s, there have actually been fewer visits to traditional allopathic physicians than to alternative-care practitioners such as chiropractors, herbalists, and acupuncturists, to name but a few of the several dozen types. Patients receive from them more affordable care of the type they feel they want and need.

Doctors use the important “laying on of hands” less than in the past. Testing replaces physical examinations. This contact accounts in part for the popularity of some alternative practitioners. It can bring about improvement in 50 to 65 percent of those with low back pain, as compared with the 35% percent who improve with advice limited to exercises and a prescription from a physician.

In addition, doctors are allowing themselves to be turned into technicians who are devoted to using procedural techniques to treat diseases, rather than becoming a specialty doctor who use procedures to treat patients with a disease.

In the hospital, a doctor of record who is responsible for a specific patient's care may call in multiple consultants, but often no doctor is actually coordinating the care.

This has created another problem. With fewer primary care doctors caring for their own patients in the hospital, there has been a progressive problem with continuity of care between the hospital care and care post-discharge.

Communication between doctors is much worse than it used to be, despite the numerous devices now available. Recently, Medicare records show that half of the patients discharged from the hospital after treatment for congestive heart failure have not seen their primary care doctor before they were prematurely readmitted at an unnecessarily high and reducible rate.

After the introduction of the diagnosis-related groups in 1983, Medicare administrators were concerned that premature discharges from the hospital would increase. I was one of a number of doctors who reviewed charts of Medicare patients who were readmitted within 30 days of discharge to determine whether this was the case.

It wasn't a problem then but by the 1990s it became a big problem. This was in part because of increasingly poor or delayed communication between hospital and primary care doctors, or because many patients did not have a primary care doctor.

In order to avoid reimbursement penalties, hospital administrators responded to these medical staff deficiencies by creating a non-physician patient navigator position. Depending on the hospital, these navigators may have different names or

more extensive duties than the traditional discharge nurse. But most of these positions – which were created to improve utilization management – are disease-focused, not patient-focused. Do Heart Disease or Cancer Navigators address all of the needs of a particular patient? Are they able to recognize conflicts in management between the different physician specialists and get them resolved? At discharge, do they make sure the patient's primary care doctor is immediately involved so that the patient gets necessary and timely care post-discharge?

One might ask, "What's so important about primary care and a trusted primary caregiver?" World Health Organization data show that in those countries, including the USA, where patients have a primary care physician, there is as much as a 19% lower mortality at up to a 35% lower cost. The coordination of care by a trusted personal doctor creates not only greater patient satisfaction but also greater efficiency of care at less cost.

Fortunately, the concept of humane, patient-centered care is coming to the fore, once again. The importance of primary care is recognized by a movement that regards primary care as the basis for good medical care. One such model is referred to as the Patient-Centered Medical Home. This concept was first proposed in the late 1960s by the American Society of Pediatrics. More recently, the medical home concept has been endorsed by a number of medical societies.

The medical home gives primacy to a personal doctor who provides the patient with continuous quality of medical advice, care, coordination, and integration with various health providers and services within the community.

This is similar to, the way medicine was practiced prior to the insertion of third-party payers between patients and their doctors. But it is certainly more complicated and demanding now.

Sixty percent of physicians now are employed by health systems rather than directly by their patients creating a conflict of interests.

There is a tacit contract between a patient and their practitioner. Ethically the patient's needs and concerns must take precedence over the practitioner's. If patients have ceded their medical purse and decision making to a third party, the requirements of the health system employer may not be in a patient's best interests. Not only *caveat emptor* (let the buyer beware) but *caveat patiens*, (let the patient beware). This can be a special problem as free market medicine flourishes.

If physician practitioners are to be part of this re-emphasis on primary care, they may benefit from less training in technology and more training in human relations to the increased benefit of the patient. Unless the emphasis in medical training changes, more and more primary care will be delivered by nurse practitioners and doctors of nursing, as well as physicians assistants and other categories of patient advocates. And, they may be *more effective*.

In any event, however this plays out, the patient – not the disease, must be their primary focus.

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That is one reason that this Awards Luncheon is very important. It honors those who focus upon the person who requires care, and not just upon the disease. My congratulations to the awardees and all those who are committed to the delivery of outstanding personal patient care.

Thank you.