James L. Holly, M.D.

An Analysis and Response to President Obama's
Health Care Reform Address to the American Medical Association
Part IV – My Healthcare Reform
By James L. Holly, MD
Your Life Your Health
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Having analyzed and responded to the President's address to the AMA, I come to the job of moving beyond the reviewing of another's agenda and of defining and describing what I think healthcare reform should look like. At the end of this essay, I will discuss what I think is the fundamental impediment to real and effective change in healthcare; it is the ideals of hope and of progress. Without these men and women, boys and girls, are not capable of making rational decisions on the basis of which they can delay gratification in order to retain or regain health.

"Reform" means "to change into an improved form or condition, to amend or improve by change of form or removal of faults and abuses." Reform then is a valid description of what we want to do with the *United States* healthcare system. We want to improve it and to remove its faults and abuses.

One of the elements missing in the recent rush to legislation for the reforming of healthcare is any statement of what is good about the healthcare system in the *United States.* First, our healthcare system invests value in all human life. There is no place where this is seen more than in the care given to prison inmates. Recently, I saw a patient who is a prisoner. While in the hospital, he was guarded around the clock by two armed guards. He is now recovering from a coronary bypass surgery and a cardiac valve replacement. One morning, the nurse who accompanied me on rounds, commented, "In my country, no prisoner would ever be given surgery such as this."

On another occasion, I treated a young man with severe heart disease who also is an inmate. The severity of his heart disease is such that he needed an AICD, which is an implanted defibrillator. As we prepared him for this almost $50,000 procedure, I said to him, "You must realize that there is no other nation on earth where you would receive this care. And, you are receiving it because our society believes correctly that you have intrinsic value regardless of where you live." The excellence of our healthcare system is seen in the fact that NO ONE is considered unworthy of care.

Second, while there are frustrations with approvals and referrals which are often required to get authorization for care, there are mechanisms in place whereby any decision with which the patient disagrees can be appealed. And while it may not appear to be so from the patient's perspective, it is a fact that the burden is heavily weighted in favor of the patient in having a healthcare provider's decision overturned in the face of an appeal. If all checks and balances are removed from the healthcare systems – economic, review, authorizations, and evidence-based criteria – the rise of cost of healthcare experienced in

the past will appear to be tortoise-change compared to the rapidity with which those costs will escalate in the future.

Third, this evidence of the excellence of our healthcare system may seem unusual, but it is the fact that anyone, for any reason, good or bad, valid or not, may challenge the care they have received and the outcome of that care in a court of law. While the legal profession has had its own "reforms," and while various opinions exist about whether things are better or worse than previous, the reality is that anyone can have their day-in-court over disappointment with the result of their healthcare. The strength of this nation is seen in the fact that no one is denied redress of grievances, no matter how one might judge the merit of the grievance.

Fourth, the standards of excellence for healthcare have no tiers. There is neither theory nor structure, which justifies or supports a difference it the quality of care to which one group or another should have access. While reform needs to make access to care more uniform, there are no institutional or structural prejudices against anyone receiving the best care available. In fact, both our society and our medical professionals spend more time, effort and public funds on efforts to improve and extend care to the poorest and neediest segments of our society than any other society on earth.

But there is more which is right about our healthcare system. For 44 years, since the beginning of Medicare and Medicaid, the people of the United States have undertaken to pay for the cost of healthcare for our most vulnerable citizens. While the cost of Medicare and Medicaid are symptomatic of the problems with our system, they are also the proof of the excellence of that system. And, the extension of Medicare into a special program entitled Medicare Advantage has enabled the most vulnerable and often the neediest of our citizens to be able to afford the accessing of healthcare. Reform of the system must be done carefully so as not to decrease the reimbursement for Medicare services below the threshold at which all physicians would have to stop seeing Medicare patients. The present target of reducing provider reimbursement by 37% over the next three years, if achieved by the reduction in per unit payments for services, will have serious and adverse affects upon healthcare reform.

End-of-life Issues

The healthcare system in the United States is the most technologically advanced in the history of medicine. And, like Medicare, this advancement is both a symptom of the problems with our heath care system, and proof of its excellence. Technology makes it possible for us to do many things which previously were only imagined, but technology also makes it possible for us to do many things which sometimes ought not to be done.

Most of the problems with the healthcare system in the United States are problems ethical, moral and religious questions, which, unanswered, compound the problems of cost and delivery of healthcare. For instance, as our populations ages, we will increasingly face the dilemma of when is care enough and when should further care not be given. These are often not medical questions; they are ethical and moral questions. It

seems clear that no one wants “rationed care,” where care is categorically denied to persons of a certain age or group. However, without “rational care,” “rationed care” will inevitably be the only economic solution to our healthcare delivery dilemma.

Only one-third of elderly Americans have living wills. There are no statistics on this question but it is anecdotally suspected that the percentage of serious, chronically ill people who don’t have a living will is high than the percentage of relatively healthy elderly who do. The majority of life-time benefits paid by Medicare are pain in the last months of life, without producing any increase in quality or quantity of life. One reform which is imperative is for healthcare providers to give more attention to addressing end-of-life issues with their elderly patients before a crisis develops in which that information is needed. Increasing insurance coverage for all Americans is a good ideal, but done without attending to issues like this is only inviting disaster.

Reform Creating Problems

Reform can create its own problems if we continue to expand the population which has no economic responsibility for the cost of their own healthcare. Economic barriers to the receipt of care must be removed, but at the same time, the patient and/or the patient’s family has to have some responsibility for the cost of their care, or the excessive demand for services will continue. This is the frustrating problem with most reforms and particularly in healthcare, any change will affect more than the focus of that change. And, while a change may positively affect the object of the reform, it may and often does adversely affect another element of the healthcare delivery equation. The dilemma is that we must not have economic barriers to needed care but without economic responsibilities unnecessary and/or unneeded care will increase.

If over-utilization of healthcare has been a problem created by providers, and, that over-utilization has seemingly been for personal economic interest, the public has delighted in and embraced that over utilization, as that same public has treated healthcare options as a delicatessen, “I want one of those and one of those and….” In order to avoid rationing of care, healthcare decisions by patients and providers must be rational. To be rational, care must be able to address the situations where we can do something else, but judgment and perhaps even wisdom dictates that it not be done.

Evidence-based Medicine

Part of the rational basis of healthcare is that it must be founded upon science and not personal experience. I shall never forget the experience I had in my first healthcare-delivery experience outside of an academic medical center. I arrived on a Friday to care for a practice’s patients until Sunday evening to allow two physicians a weekend off. The doctors ran was a small 30-bed proprietary hospital. I rounded on all 30 patients; yes, it was full. None of the patients had a history and physical, progress note, or a treatment plan, so I completed all of the charts. I then discharged 29 of the patients, as they had no need to be in the hospital.

Seventy-two hours later, I learned the reality of healthcare. On Monday morning, I received an irate call from one of the physicians. He had called all of the patients and put them back in the hospital. As if that were not enough, I returned once more to this practice. This time in a Saturday morning clinic, the junior physician sidled up to me and whispered, as I prepared to treat a strep throat in a child, "I have found that if you add a little steroid with the penicillin, they feel better real fast." While most physicians' personal experience does not lead to this poor and dangerous a conclusion, personal experience is a poor basis on which to judge treatment options.

Information Technology

The only way that evidence-based medicine can be accessible to all healthcare providers is through information systems, i.e., computer technology. In his seminal work, *The Fifth Discipline*, Dr. Peter Senge, while analyzing business structures, identified the problem with which healthcare is faced today. He stated: **"**System thinking is needed more than ever because for the first time in history, humankind has the capacity:

- To create far more information than anyone can absorb,
- To foster far greater interdependency than anyone can manage
- To accelerate change far faster than anyone's ability to keep pace."

Depending upon how you count, there are between 4,000 and 7,000 medically-related journals presently being published. There are over 1,000 medically-related journal articles published each day. In 2004, the *Journal of the Medical Library Association* published an article entitled, "How Much Effort is needed to keep up with the literature relevant to primary care?" Here are the authors' conclusions:

- There are 341 currently active journals which are relevant to primary care.
- These journals publish approximately 7,287 articles monthly.
- It would take physicians trained in epidemiology an estimated 627.5 hours per month to read and evaluate these articles. That translates into 21 hours a day, seven days a week, every month.

In 1997, *The British Medical Journal* stated that there are over 10,000,000 medically-related articles on library shelves of which about 1/3rd are indexed in the Medline database compiled by the National Library of Medicine.

This is the level of the problem for individual physicians, but what about collaborative efforts to organize medical data? The Cochrane Collaboration was started in 1992 following Dr. Archie Cochrane's 1979 statement in which he opined "It is surely a great criticism of our profession that we have not organized a critical summary, by specialty or subspecialty, adapted periodically, of all relevant randomized controlled trials."

There are now fifteen Cochrane Centers around the world with 1,098 complete reviews and 866 protocols (reviews in progress). It is estimated that it will take 30 years to complete reviews on random-controlled studies (RCTs) in all fields of medicine which

presently exist. At the end of those 30 years, nothing would have been done on the RCTs which will have been completed in the intervening 30 years.

Without medical knowledge, quality-of-care initiatives will falter, but the volume of medical knowledge is so vast that it can overwhelm healthcare providers. Stated a different way, the good news about healthcare today is the state of our current knowledge; it is excellent. The bad news is the form in which that knowledge is stored and/or accessed. Effective healthcare reform is not possible without an information technology revolution in healthcare.

Coordination of Care

For too long, healthcare has been organized around episodic and, most often, acute-care encounters with a healthcare professional. Care has often lacked organization with a patient going to one specialist to be referred by that specialist to another specialist and then to another, without anyone being responsible for anything but their narrow area of interest in the patient's condition. If real reform is going to take place in healthcare, there must be a fulcrum (a pivot) and a locus (a place) where the power – the leverage – of the excellent science we have in medicine can be brought to bear on each, individual patient's healthcare need, every time they seek care. And, there must be a place to which the patient looks for counsel, guidance and information with which to make rational decisions about their healthcare.

There are many initiatives which are working toward the goal of coordinated care, such as patient-centered medical home, accountability care organizations and others. It is imperative that healthcare reform change reimbursement patters to value this service to patients and to the public interest, in order to allow primary-care physicians and nurse practitioners to provide these kind of services intentionally rather than occasionally and incidentally to acute or chronic care needs.

Physicians as Entrepreneurs

The reform which is being discussed today has as its foundation the decreasing of payments made to healthcare providers. While this is denied publicly, privately it admitted that such reductions are the backbone of Federal reform. This reform will accentuate the problem which has been created in the past where physicians and other healthcare providers in a self-defensive reaction have begun to focus on the business of medicine. Fearing that they cannot rely upon practicing medicine to secure their financial futures, they diversify, often causing them to lose their focus on improving healthcare. Any reform which aggressively decreases reimbursement to providers will have the undesired effect of causing providers to try to find other ways of supplementing their incomes which may result in the increasing of the neglect of the critical issues which reform intends. For reform to avoid this potential pitfall, there has to be a balance between provider and public interests. Reformers must not unwittingly destroy the system which they are trying to reform.

Hope and Progress

The President declares that his plans and science can cure "cancer, diabetes, lung disease, cardiovascular disease and strokes." While this is patently not true, any chance for seriously improving these conditions, particularly in the uninsured, is going to be founded on hope and the idea of progress, not simply on science. Personal healthcare improvement requires a delay in gratification in order to lose weight, exercise, stop smoking, take medicine and change a myriad of other lifestyles. In 1921, when J. B. Bury published his book, *The Idea of Progress: An Inquiry into Its Origin and Growth*, he traced the growth of the idea that things could change and that they could change for the better. Hope and progress are twins – you really can't have one without the other.

For a person not to eat unhealthy foods, they must have the hope that denying themselves short-term pleasure will make a difference in their long-term health. They must believe that they will progress toward a desired goal. Yet millions of people in the world and even in the United States have generations of experience which suggest to them that no matter what they do, it will not make a difference. They "feel," if not believe, that there is no hope and no progress. When a person doesn't expect to live longer and when living longer is just a function of the same frustration, emptiness and hopelessness, making a healthcare decision to change their lifestyle seems futile.

Hope is not essentially a healthcare delivery problem but without it, any reform will fail. Without the audacity of hope, healthcare reform will never succeed.