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Rita,

Thanks for sending me a copy of your book "Healthcare at a Turning Point."<sup>i</sup> I have read it with interest. You will not be surprised to find that I agree with your analysis about our current state of affairs and how we got there, particularly the perverse incentives that have proven so difficult to eliminate.

I do wish to share a couple of thoughts I have formed over the years that may be relevant to your analysis. First, I find it helpful to think about medical care, a term I prefer to "healthcare," as having several different domains. The first is that of the acute, usually self-limited illness. This was the dominant sort of episode of care when the fee for service payment model was developed, and it works fairly well there. Most of these illnesses are the sort that the retail "doc in box" (although usually really a nurse practitioner) operations deal with. These really should be cash only businesses. However, of the 50 or so primary care doctors in my 140 provider group, almost 20% of them are doing this kind of work in one of our after-hours urgent care centers. It would certainly be cheaper for the patient and us if the encounter was a cash operation—the charge could be reduced at least 50% and the doctor would still be reaching his income targets. This is also an area in which it is reasonably simple to develop treatment pathways.

The second domain is that of the relatively intense, short-term episode of care requiring hospitalization for treatment. This is the fractured hip, the heart attack, etc. At one time hospitals depended upon a lot of elective procedures, but these are almost all done as outpatients these days. These are the sorts of admissions for which care pathways can/have been developed. I agree with your notion that IT could be leveraged to find out which of the hundred of ad hoc care pathways for these common problems works best and develop "standard pathways" for them. As a practicing physician, my only caveat is that you allow for some reasonable percentage of people to "fall off the pathway" because of biologic variability. This is the group for which traditional hospitalization insurance was developed. It works reasonably well, because few of these conditions recur. You can only take the gallbladder or appendix out once, and the patient with pneumonia gets well and goes home.

The third domain is where I live, which is the care of chronic conditions. I have seen estimates that this is now 50% of outpatient encounters, which, if correct, is at least a doubling of the rate from when I entered practice 30 years ago. When I started, the oncologist and I were the weird guys, because we wanted a medical chart that we could actually use to keep track of important patient data over time and institutions. I remember a conversation with the Clinic administrator where I asked why we could not at least buy some tabbed dividers to separate various parts of the chart. He told me that 90% of our office encounters were such that the doctor would never have occasion to look at the data again. (He led the charge to EMR conversion, so we have lab data and chart data digitized going back to 1995, and are on our third EMR).

This third domain also dominates the hospital. I point out from time to time that on any given day, half of the inpatients in our facility have been there at least once in the past year, yet we still treat each admission as if it were occurring in isolation. In fact the hospital EMR is quite good at digitizing HOSPITAL processes, and nearly useless for recording, retaining, and retrieving PATIENT information. As a result, we still find it better to dictate critical summaries so we can communicate with the "outside" world, including each other.

Since I have spent the past 35 years doing chronic disease management, and a lot of my public speaking/writing has been on the CQI model (including cost), I have a couple of additional points I would like to make relative to your book's arguments.

First, when faced with life-threatening diseases, we are not consumers. Even if we had to pay the bill directly, we generally want "the best" and we generally want a high degree of certainty. Sadly, we do not have, and I suspect will never have, the degree of certainty people want. As I once told Rep. Jim Cooper, (D-TN) who was one of the proponents of healthcare reform during the Clinton administration, the problem is we are trying to design rational systems to deal with fundamentally irrational issues. None of us really wants to be sick, hurt, or die. We certainly need more patient (consumer) involvement in decision making than is "usual and customary," but I really think analogies with buying the latest Apple gizmo or car repairs fail to capture reality. After all, we can trade the clunker in on a new model, but most of us are not in any hurry to change our corporal clunker into a new model.

Second, the currently available process indicators, which you mention in a number of places, don't correlate particularly well with either patient preferences or desirable outcomes. This is not to suggest that we should stop working on them, but we need to be a whole lot smarter about it.

Third, you talk a lot about prevention as a cost saver. We have darn few things that have actually been demonstrated to be preventive. A lot of what we do is delay. Let me give you a concrete example—heart attacks. We know that stopping cigarette smoking is a big plus in reducing the RATE of heart attacks in a given year, and probably in the absolute number of people who have a heart attack. Statins, on the other hand, are not clearly effective for primary prevention in the general population, and even in enriched populations of people at high risk, we probably delay the age at which the heart attack occurs more than we prevent them altogether.

Fourth, most of our guidelines deal with individual disease states in isolation, without considering the real life situation where the patient has more than one disease. I sometimes say that a primary care doctor who is rigorously committed to guideline implementation will have his healthy 70 year old patient on at least 10 medications. (Guideline development is generally funded by big Pharma. Hmmm.)

Lastly, "bending the cost curve" requires societal consensus on when "I'm too old for that." I went to Australia on sabbatical in 1992, and spent time in their major centers trying to find out why they did not have any elderly patients on dialysis. I assumed they were "rationing" the care. When I talked to them, though, they really did not understand the problem, because they just did not see these patients in consultation. When I explored the definition of old age in Australian society, it turned out that 70 was the goal. Any years after that were bonus, but certainly not something to be obtained with intrusive medical care. I started asking American physicians at what age they started finding patients who would refuse dialysis, not because of their co-morbid conditions, but simply on the basis of age. The answer was always 80, if they did not say "never." I started asking the question again recently of some younger physicians, whose enthusiasm I was trying to temper, and they said "90." Obviously, no protocol or payment mechanism provides a neat solution to this problem.

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<sup>i</sup> <http://www.healthcareturningpoint.com/>