

## Discussion

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Atul Gawande, in his book, "Better: A Surgeon's Notes on Performance," states (with a bit of modification): "Arriving at meaningful solutions is an inevitably slow and difficult process. Better is possible. It does not take genius. It takes DILIGENCE, MORAL CLARITY, INGENUITY, AND THE WILLINESS TO TRY."

### **AUTONOMY**

The present health care system destroys humanism in their providers by micro managing the delivery of care. Those who currently make the rules have never been humanistic in their limited approach to direct patient involvement. The corporate mentality and single minded goal of profit and domination supersedes morality, professionalism, ethical behavior and patient and provider autonomy.

As reimbursements declined with managed care and with huge malpractice expenses, many physicians sought the business benefit to becoming a part of a large system. The first few months go well as business demands are out-sourced, however except for the provider on a retirement-soon track, it is not long before the controlling aspects of corporate medicine wear thin the veneer of professional pride, satisfaction and value.

Patients too have had to succumb to insurance domination and have suffered the health care consequences along the way – We all have multiple stories of inequities - the financial disasters of families are legion. Time constraints limit the physician's ability to spend time with patient education, explanation and thorough evaluation. With all the complicated options of today's therapies, more time, not less, should be allowed. A recent study of several neurosurgeons spending time with patients on informed consent – then using group discussions with a Master's nurse and again another day before surgery session discovered that only 52% of the material was retained. Perhaps the fact that in large institutions the residents and nurses do the pre and post procedure education is better use of time. I hardly think so but I could be wrong. One wealthy gentleman arriving by his private jet insisted to see his surgeon personally or he would seek care elsewhere. His very appropriate demand was accomplished with much grudging and reluctance on the part of the surgeon. Have we forgotten who we are – or perhaps this is what we are or perhaps should become. Will we use our strained resources better by these patterns?

Assuming we improve the system to have time and resources to educate our patients, we must first be sure we use the terminology that is understandable. Your homework illustrates the use of different words to illustrate a concept. Dr. Joanne Schwartzberg last year showed a very impressive video of patients who look and act like you and me – except they were illiterate. Last night's homework indicates how changing the words make it hard to understand the concepts. Repetition in teaching, involving the patient in conversation about their health and follow-up is essential for optimum results. With the right amount of time and with "medical homes" with good primary care we could have an excellent health care system that works for both provider and recipient. Most of us have worked as a primary care providers – we know how relationships work and we care enough to take the time to do it well. Can this continue in today's environment? Not unless we expect it – demand it and work to achieve it.

In Cleveland there have been many changes in the medical interaction with patients. Recorded Visit Units are the hallmark of reimbursement and requirements are mandated for providers. Computer documentation is paramount to the visit with less personal connection - body language or eye contact is reduced. Records are online but only available to the particular medical entity that the physician/patient belongs to. There is no computer connection, for example, between the Cleveland Clinic, the VA and Case University Hospitals – the three largest systems. If a patient has multiple problems or diagnoses he needs to make visits separate for each problem since there are time restraints for visits. The health care system is manipulated by money.

Joint Commission accredits offices of major conglomerates at high fees. Thumbprints are required to access medications. Samples are no longer allowed. No liquids are available to the physician (pap smear, hydrogen peroxide, alcohol, even occult blood test strips). Rooms are no longer stocked with supplies as a safety measure. No hand cream or soap in bathrooms. Individual dispensing required. Chaperones during exams are NOT done –money is saved.

Nurse visits for minor check (BP or teaching) are billed at \$60 instead of a courtesy visit. Nurses are not allowed to run u/a or throat culture without written orders. If a patient has any other than a system insurance they are required to make a special appointment to pay ahead or make specific arrangements. A young woman just back from Iraq with a State Department Insurance form was denied care until she pre-paid. When the physician himself offered to take responsibility it was denied. What an insult. Even patients of good standing for 25 years are subject to these new rules.

A Stepford wives mentality now exists and the computer generates specific treatment requirements despite the physician's knowledge of the individual patients needs. A complete review of health maintenance information and allergy reviews must be downloaded before actual care can be advanced. These steps take precious time for the brief office visits that are structured.

Some systems demand total control. If an employee smokes, discharge is mandatory. In the hiring process if the urinalysis shows recent smoking even if person is in process of cessation, that person is automatically excluded. The latest issue has been cholesterol and weight and pedometer controlled activity or insurance will be increased by \$300

Phoenix College offers courses that are required for employees at one institution. The 7 AM required conferences were dropped to save pay-roll dollars.

Employees in one system are required to wear a button saying "Patients First." Many think it should say "Finance First."

## **DIVERSITY**

And we are expected in this global world to embrace diversity. In 1954 my class of 80 had a few women a few Jews one Asian and the majority WASP's. At today's white coat ceremony there are no Smiths Browns Jones Johnsons Browns or Whites. The roll call sounds like the United Nations. As we work together with diverse cultures, religions and ethnicities are we willing to embrace these differences? Thus far not so much. Middle Easterners refer to Middle Easterners – women to women, Jews to Jews. As I look around this room there is very little diversity. I recall our panel of last year and the comments of the two young women about their perception of our group. There was an outcry of resentment and a strong defensive reaction that we were really OK. We are comfortable with our own.

I was introduced to a book first published in 1980 written by Rosabeth Moss Kanter, "A Tale of 'O': On Being Different in an Organization." The two characters in the book - the large number of X's and the few "O"s describe their interactions and how they cope - or don't cope. It is a simple fun demonstration of being a minority in a well established community. My own experience of being the first female in 22 years at MacDonald Hospital, Case Western Reserve University, Cleveland, and being trivialized and marginalized, contrasts with the tremendous change in the current atmosphere when the medical school matriculated 1/3 female students. From that time forward the previous paternalistic power was slowly reduced to a more patient/physician partnership. At that time in the mid 70's many physicians required a husband's written permission for his wife's sterilization though the wife's permission was not required for a vasectomy.

A few years ago a wonderful Afro-American female resident was job hunting and we had lunch as we discussed her joining my practice. She specifically asked "Would your patients object to my caring for them being of another race". My answer was of course, that would be their problem - not ours. She got a much better offer and is now internationally known in her field - Certainly far above her expectation when she finished her training. A good step in the right direction but still a psychological hurdle at first.

So what are the solutions to the problems that are presented here? Patient and provider AUTONOMY requires a loud voice - almost a civil rights movement that says we do not want this system - we want to be heard so that we get our money's worth of health care solutions. We want less business - more care - more relationships - more partnership. It was my hope that an academic university would do a research project on health care systems without the burden of politics, lobbyists, and special interest groups. Thus far it is a program that I have outlined and shared but have been unable to sell in a meaningful way. The Mayo clinic has been doing some of this research in the past three years, focusing on access, quality and affordability. Patient surveys want less government control, more information, and no more taxes for the system, oppose financial incentives for quality. The study criticizes politics, insurers and government involvement.

The movement to DIVERSITY is already in place and developing nicely. The older generation should stay out of the way - do not impose our opinions - let the young professionals succeed in the global marketplace. It is happening as we speak. Our young students deal with these differences more successfully than we have. Many arrive expecting to serve in developing countries - the world is smaller and more easily accessible to home and family. The international experiences and international friendships are multiplied tenfold over experiences of a generation or two in the past. Our legacy has not always been particularly admirable but the times are favorable for change. Our children and grandchildren are open to exploring and sampling new cultures and new experiences.

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