

# The empowered physician

Nileen Verbeten

**E**conomic, demographic, technological, political, and cultural forces are converging and few in health care are ready. There has never been a time when physician engagement is more important and widespread mobilization is required. Medical societies' political and legal advocacy remains critically important. However, these efforts, while necessary, are insufficient. Medicine is confronted by changes of unprecedented magnitude that call every physician to action—but what action?

In evaluating needed action, we can start with a review of systems.

*Economic systems are weakening.* US expenditures for health care continue to grow in dollars and as a percent of Gross National Product (GNP). We spend twice as much on health care per capita as other industrialized countries and, unlike these countries, have 47 million people without access to regular care. These expenditures are competing for other things strongly correlated with health: education, housing, income.

*Funding systems are unstable.* Employers decry the loss of global competitiveness and are exploring all strategies to reduce their spending on employee health care. Some options so far include elimination

of health care benefits, shifting from guaranteed health care (traditional health insurance) to defined contribution (consumer directed health care and health savings accounts), increased employee cost sharing, outsourcing (barely noticeable but rapidly growing use of overseas care centers for example), bringing health care in-house, and funding care management programs imposed upon the delivery system.

*Reimbursement systems are broken.* The disconnect between what is needed and what is rewarded is increasingly apparent.

*Demands are rising.* Physicians have more and costlier interventions at their disposal. Prevalence and intensity of chronic conditions are increasing. The graying baby boomers will exacerbate pressures on the system as their health and abilities deteriorate but expectations do not.

*Technology is accelerating at an unprecedented pace.* The explosion of new drugs and clinical knowledge offers dramatic hope for many diseases while at the same time making it impossible for even the most brilliant and best trained physician to retain all relevant information in memory. Rapidly developing health information technology (HIT), though far from perfect, has the potential to accumulate and deliver vast amounts of relevant information to the physician instantly. Because more is possible, more is expected.

*Political forces are confounding solutions.* The cost of medical events is the leading cause of personal bankruptcy in the US today. A growing portion of the American public is concerned about the absence or potential loss of health care coverage.

The furor of employers whose ability to compete on the world market is loud and clear. The burden of health care costs on state and federal coffers is unsustainable. Policymakers are tied in knots coping with 2 valued constituencies—those who provide health care and those who pay for it. There will come a point when sheer economics will trump political muscle.

*Cultural icons are falling.* Fading away are the generations who trusted institutions, traditions, and authority—and who deferred to their doctor. In their place are younger generations with high personal expectations of getting what they want, when and where they want it, and in the preferred manner—who have unlimited access to information, distrust of authority, and a greater financial stake in choices being made.

In short, the US health care system as patient is very, very ill.

## So what is a doctor to do?

What constitutes engagement in this context? The most comfortable and embraced activities in organized medicine strive to influence policymakers about the concerns of physicians—quite often focused primarily on the economic concerns. This has been successful in the past and speaks directly to the pain physicians are experiencing. Physician leadership in matters of policy is essential. Long-term effectiveness will be limited by the extent to which physicians listen and act on the concerns of other stakeholders in this problem.

More difficult engagement and leadership is called for given today's unrest. Many physicians feel oppressed, bewildered, and angry. These feelings are understandable.

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The long, arduous, and expensive process to become a physician culls out all but the most dedicated, brightest, and best. Finding oneself in an environment of changing resources, expectations and rules is a rational basis for anger and resistance. "I am working very hard. My focus is on my patients. Nothing more should be expected of me." Understandable, yes. Probably not any more productive, however, than the patient with a treatable but life threatening condition who cannot progress beyond railing about the unfairness of it all and shuns care that would offer hope.

Through engagement, physicians can become empowered. They can embrace the forces driving change and leverage them. No one needs to like these forces. No one needs to believe them fair or just. They just are. Cancer is not fair or just. It just is.

### **But how does a physician become empowered?**

A good starting point might be the proud embrace of contributions physicians have made to the problems our health care system is facing. Without major advances in medicine and dedicated work of physicians, we would not be so challenged by the demands of chronic illness. Patients could have died much earlier of heart disease, cancer, or pneumonia. Much of today's problems are the result of yesterday's successes.

A next step might be to recognize that just as physicians have learned new skills and have new tools to manage yesterday's scourges, old approaches do not address today's challenges.

Seventy-five percent of today's health care dollars are expended on chronic conditions. Unlike acute conditions where the physician's technical skill can fix the problem, chronic conditions require the active participation of the patient. Managing these conditions requires attention to

a host of clinical issues and engaging patients in new and profound ways. No small challenge, since patients are becoming more independent, more informed, more skeptical, more financially at risk—in short, more likely, able, and motivated to question the physician.

The engaged, empowered physician realizes that old tools and processes will not address today's challenges. This is where the hard work begins. No one can provide a simple answer for what to do. Solutions necessitated by external changes cannot be externally imposed. The physician cannot make the patient with diabetes make proper choices to best deal with his or her disease. Similarly, no one can make the physician embrace choices that position his or her practice for success in an increasingly challenging environment.

Embracing new choices means opening oneself to the belief that testing new ways is necessary. For instance, a Duke University study<sup>1</sup> found that providing all recommended care for the top 10 chronic conditions for patients in good control would require 3.5 additional hours every day for every primary care physician and that managing uncontrolled disease would require 10.6 additional hours per day. With such findings, it is tempting to throw up one's hands and say this is impossible. Delivering the care defined as best practice is too costly. It cannot be done. But it was not so long ago when curing cancer was viewed as impossible, too.

It is quite clear that many physicians, especially primary care physicians, cannot work harder. Bruising demands of today's reimbursement systems have pushed many to the breaking point. Reimbursement incentives need to change. But it is also quite clear that the acute care orientation of physician office practice is not designed for the predictable needs of today's population. Reimbursement is not going to fund

10.6 additional hours per day for every primary care physician, even if it were possible for the physician to give more time.

Empowered physicians explore ways to embrace this challenge. Where might efficiencies that decrease costs be found, making it possible to see fewer patients for longer periods? Emerging technology tools—ranging from simple to complex—have proven this possible. How might the physician's practice be designed to perform the predictable work required of chronic conditions—for all of the patients who rely on that practice—whether they are coming in for visits or not? Inexpensive tools exist to help with this and, used well, they can save physicians time. How can process measures expected for these conditions be reliably provided while paying full attention to the expressed concerns of patients who may have other matters on their mind? The traditional organization of the office visit cannot achieve this. Team approaches, flexible methods of communicating with patients, and alternative types of visits are all showing significant promise.

Being empowered requires openness and confidence that physicians will find ways to deal with this problem. Advocacy on matters of public policy is critically important and will be done. Many organizations are hard at work to develop resources and tools to help. But the most difficult challenge for physicians this time may be internalizing the problem to find the solutions within.

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### **Reference**

1. Department of Community and Family Medicine, Duke University Medical Center, "Is There Time for Management of Patients With Chronic Diseases in Primary Care?" *Annals of Family Medicine*, Vol. 3, 209-214, 2005..

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