



Infectious disease expert Dr. Manjari Joshi and patient.

Photo © Mark Tuschman.



The Doctor, 1891. Sir Luke Fildes (1844-1927). Oil on canvas, 166.4 x 241.9 cm. The Tate Gallery, London. Photo credit: Tate, London/Art Resource, NY.

The care of the patient

Jeremiah A. Barondess, MD

The author (AQA, Johns Hopkins University, 1949) is the president emeritus of the New York Academy of Medicine, a past president of AQA, and a member of the editorial board of *The Pharos*. This paper was presented at a 2000 Symposium on the Doctor at the Millennium.

When Francis Peabody's paper "The Care of the Patient" was published in 1927,¹ the clinical transaction was less impacted by the presence of other players and other forces than it is at present. The use of Peabody's title for this paper is meant to highlight the differences.

Although written more than a decade ago, developments in the care system since then, including the Patient Protection and Affordable Care Act of 2010, have not yet altered the landscape described nor the views expressed here.

Powerful forces have rearranged the organization of health care in this country in recent years, impinging significantly on the priorities of the system.

Two viewpoints are foremost:

- One is that of physicians, who feel their ability to deliver an undoubted and complex social good in proper fashion is being intruded upon.

- The other sees physicians as unable to exercise adequate economic stewardship of the health care system. Even though recent changes have taken significant control of the clinical care system out of the hands of the profession, some feel that the process has not yet gone far enough.

Concerns about the care of patients are also widely voiced. These include:

- Concerns about quality of care, the underuse of effective treatments on the one hand, the overuse of ineffective or dangerous ones on the other, and a disturbing frequency of medical errors.

- Concerns about loss of clinical autonomy, which are counterbalanced by evidence of widespread variation in the application of clinical procedures, such as between individual cities and even entire states.

- Professionalism in medicine is seen by many as endangered.

- Widespread worries exist about maintaining the primacy of the physician's responsibility as the agent of the patient.

- Commercialism in medicine has increased to a remarkable and very troubling degree.

If we are at present in disarray, if the economy of health care is unstable and requires revision, and if clinical priorities and the concerns of patients are a significant issue, there is enough culpability to go around. Some of it is due to early iterations of the managed care movement, and some to structures and procedures we ourselves have developed over the decades.

Julius Richmond and Rashi Fein² tell us in their 2005 book, *The Health Care Mess*, that as managed care emerged, the organized health care professions contributed to the erosion of professionalism by relaxing the taboos against the corporate practice of medicine and advertising (and embracing

unionization). In the process, as the physician's role in clinical decision making, diagnosis, and management was reduced, focus on the individual patient was gradually replaced by general information about the average patient available on computers to support the decisions of insurance carriers. Richmond and Fein further wrote, "That persons needing care should be the center of the health care enterprise was lost sight of as health care professionals lost influence in developing public policies."² The *economics* of health care had become the primary engine of change.

From the point of view of physicians, the system that has emerged is intrusive and obstructs efforts to deliver high quality care, while the overarching concern about controlling health care costs adversely impacts the needs of individual patients. From the point of view of policymakers and health economists, control of health care costs is a valid primary concern that has required a systemic response with the goal of economic rationality and enhanced quality of care for patients as a whole. Ironically, each side shares, I believe to an increasing degree, the concerns of the other. Ultimately, public policy and practice systems must take account of and protect the individual clinical transaction through more innovative, patient-centered arrangements, while the clinical enterprise must come to grips with the need to control the cost and quality elements that are in the hands of the physician.

The problems

The situation that we're in seems to me to reflect the dual nature of medicine: on the one hand its *content and capacities*, and on the other its *application*. Traditionally, *content and capacities* were based in a strong humanitarian tradition in the medical profession, on the evaluation of patient needs and clinical processes, and on biomedical science (as Peabody pointed out). Over the last fifty years or so, a phenomenally successful biological science has developed as the base for medicine. We have moved from clinical syndromes to organ physiology to cellular mechanisms, and now to the molecular basis of human physiology and disease. With this has come extraordinary and very expensive derivative technological capacities. These technologies have found wide clinical application and have in fact emerged as one of the chief drivers of health care costs. So successful has been the development of the science and technology base of clinical practice, and so broad and sophisticated are the technologies, that we have come to largely consider science and technology to *be* medicine, a stance that underlies some of our problems, including the increasing dismay of some physicians and many of our patients.

With regard to the *application* of medicine, things have been somewhat different. Application is based on individual

and societal need and reflects dual implicit contracts—on the one hand between the medical enterprise and society, and on the other between the individual physician and the individual patient. In contrast to the continuing success of science and technology in medicine, the contracts haven't fared so well. On the side of the contract with society, for example:

- A cottage-industry model for medical practice, lacking adequate fiscal and quality control, persisted until large purchasers and policy makers forced rearrangements on the medical establishment.
- Costs have risen extraordinarily, and far more than in other industrialized countries.
- Practice variation has emerged due to a mix of forces, including lack of an adequate information base to validate best practices, as well as regional practice norms and perceived fiscal opportunities.
- Connections between clinical medicine, the public health enterprise, and disease prevention efforts are weak and inconstant.

Contract failings are also apparent in the doctor/patient relationship:

- Basic clinical skills have eroded significantly as we have moved toward substituting technologies for clinical acumen.
- We have "biologized" the sick person, focusing on the recognition and management of disease as a set of biologic phenomena, often to the neglect of associated, illness-related human needs.
- We continue to use antiquated, costly, and demonstrably useless clinical routines, such as batteries of admission or preoperative or screening tests dissociated from clinical evaluation of the patient.

Is it any wonder that patients are increasingly expressing dissatisfaction, finding physicians hurried, impersonal, functioning to an increasing and disturbing degree as technical experts and triage managers, and less as healers? In addition, significant agency issues have arisen for patients, who wonder who is their primary agent: the physician, the managed-care plan, the practice group, or the hospital. Physicians are also dissatisfied, about clinical autonomy, the time required to deal with carriers, the disruption of referral patterns, and changing rosters of patients as employers shift carriers and plans.

Further, some of the problems of the clinical care system that have developed are of our own making:

- We have both narrowed and diluted clinical responsibility by the extraordinary growth of subspecialization in clinical care. This is perhaps most notable in internal medicine, which is responsible for the care of most of the population most of the time. Excessive subspecialization has resulted in higher costs, technologic intensity, and a pattern of referrals to other subspecialists, further increasing costs and fragmenting clinical care without—except for a few instances—demonstrable benefit compared with sophisticated generalist care. Countries that have not embraced subspecialization to the

same degree show no significant differences in patient outcomes while having substantially lower health care costs.

- At the same time, we have merged the generalist specialties under the rubric of “primary care,” an ill-defined concept that, combined with our move toward subspecialization, has resulted in divorcing generalists—particularly general internists—from the management of complex disease and the overall controlling responsibility for the care of the patient. “Primary care” is not a field, but a function, a level of care shared by a number of specialties and some subspecialists, as well as nurse practitioners, physician assistants, and others. It includes access to care, triage, the management of acute and often self-limited disorders, and the ongoing care of ambulatory patients with a variety of chronic diseases. We should recognize that the primary care concept contributes to costs because it fuels more use of our system of subspecialist-oriented care. In addition, the emergence of “hospitalists” further separates generalist physicians, especially internists, from the management of severe disease, further fragmenting care, and further jeopardizing the personal physician’s stewardship of the health of the patient.

The needs

In pointing out some of these problems, I am not suggesting that the care given in this country is generally defective. But the issues are many: costs *are* excessive, much of clinical care *is* fragmented, we *have* tended to “biologize” the sick person, and new information about quality concerns is not applied in a timely fashion. Some of what we do could and should be better. New systems of care are emerging, new points of decision and new deciders have emerged as primary shapers of health care, and there are new demands for accountability and further systematization. Flux in the system is increasing, not waning. The central question for physicians is whether, as this process proceeds, we will be at the center of shaping it to assure that individual patients and their needs are the focus.

What do patients need? While the description is not complex, there are significant complexities in the execution:

1. *Patients need high quality care.* This includes being able to access current knowledge and expertise in a timely way.
2. *Patients need their choice of physicians.* Further, they need to know that they can keep their chosen physicians without interference from outside entities.
3. *Patients need to access their care at reasonable personal incurred cost,* and, linked to this, reasonable, focused, and restrained application of clinical technologies.
4. *Patients need professionalism.* Professionalism has been variously defined. I would emphasize five components:
 - *Competence,* primarily clinical competence and

carefully applied and well-developed clinical skills. These drive the shape, priorities, and content of the clinical transaction. They must be informed by the relevant biology and clinical literature, as well as by a capacity to see the wider picture that can tie the clinical problem to its causes and to prevention and public health issues.

- *Engagement,* in the patient’s health generally, and in the particular clinical problem. This includes empathic engagement and expressed concern, but also engagement in the sense of a functional personal alliance. This concept embraces both the Samaritan functions of the physician to help, support, and counsel, as described some years ago by Walsh McDermott,⁴ and the “healer” role recently emphasized by Richard and Sylvia Creuss.⁵ In my lexicon, engagement includes joint ownership of the patient’s problem.

- *Reliability,* meaning access to the doctor, including his or her clinical competence, help in navigating the health care system, and comprehensive stewardship of the patient’s care. Constancy of engagement is the core of reliability.

- *Dignity.* Something serious and important is going on between doctor and patient, requiring a dignified relationship, a dignified clinical transaction, dignified counseling and treatment, and a dignified physician. It is the patient’s need that merits and requires this, the proffering of his or her need.

- *Agency* is a concept that implies alliance and commitment to the patient’s health and problem as the primary factors in mobilizing, shaping, and supporting the other elements I have described.

The care of the patient

Every patient should expect to be treated as a unique person with a unique problem, and to have that uniqueness respected in all parts of the clinical transaction. Protecting this uniqueness in the face of the need for better systems will continue to be a central problem for us in the further evolution of our care system. Any patient should expect that his or her clinical care will have:

- A dual focus on illness and disease: With our increasing scientific sophistication we have tended to focus on disease phenomena and their management, and regarded that orientation as satisfying our responsibilities as physicians. But it does not—every disease is attached to a person with a need for caring, symptom relief, explanations, and a prognosis.
- Referral parsimony: Depth of competence among generalists would reduce referrals to multiple subspecialists and help to move us back toward more coherent care. This would require greater willingness to own the management of complex or advanced disease among internists.

The care of the patient

- Validation: We must insist on the validation of clinical processes to promote increasingly rational practice.
- Cost awareness: Every clinical encounter and practice mode should be based on what is *best* for the patient, and should include awareness of the aggregate costs of health care.

What to do?

In particular, what can physicians do to contribute to development of a more satisfactory, patient-centered system? Today various priorities, especially cost management and quality care are championed by various sectors. But physician cooperation is essential to the resolution of cost concerns and is the single most important force in protecting clinical quality.

What is needed, it seems to me, is something like the following:

1. Medical education needs to work urgently toward a re-emphasis on high-grade clinical skills and for a care paradigm that is *patient centered*. Such a paradigm should be based both on clinical competence and on the human needs of the sick.
2. Physicians must lead the fight to reaffirm the focus of medicine and the health care system on the proper care of the *patient*. They must join with policy makers, payers, and the health care systems community to produce a system that includes the concerns they represent within the context of patient-centered care.
3. Physicians need to take the lead in the further shift of medical practice toward a system that is founded on compassion, rational systems, accountability, effective cost management, and practice efficiencies.
4. Physicians must become familiar with the basic economics of health services, and make greater efforts to understand the economic forces at work, the population perspective, and system responses to the linked issues of cost and quality. This will enable them to engage intelligently in shaping the discussion about the future. The recent appearance of such material in clinical journals should be expanded.
5. Physicians need to lead the fight against commercialism in medicine. Today's pervasive commercialism corrodes professionalism and trust and engenders cynicism, especially among trainees. Advertising by individual physicians and cocktail receptions to trumpet new facilities are deeply harmful to medicine's service ethic because they highlight the welfare of the doctor, not the patient.
6. Physicians should push clinical training centers, specialty boards, and clinical societies to revamp our array of subspecialties to bring the ever-proliferating number under control. We need to expand the competencies and capacities of specialists in general fields, primarily internal medicine, because that is where most of the care of most of the population occurs, and



Dr. Phillip Pizzo examines a patient. Photo © Mark Tuschman.

because sophisticated generalism would bring about better cost control and less fragmented, more coherent care.

Back to the care of the patient

Health care today cannot be reshaped, nor can the imperative for the care of the patient be regained, until society's concerns about costs and agency are effectively addressed. Physicians must lead in the fight for quality and equity in health care, for professionalism and idealism, and commitment to the deep responsibilities of our profession—rational, restrained, effective, and supportive care.

For the individual doctor and patient, as well as for the health care system at large, our focus must be, as it always has been and as Peabody said, on *the care of the patient*.

References

1. Peabody FW. The care of the patient. JAMA 1927; 88: 877–82.
2. Richmond JB, Fein R. The Health Care Mess: How We Got Into It and What It Will Take to Get Out. Cambridge (MA): Harvard University Press; 2005.
3. McDermott W. Medicine: the public good and one's own. Perspect Biol Med 1978; 21: 167–87.
4. Cruess RL, Cruess SR. Teaching medicine as a profession in the service of healing. Acad Med 1997; 72: 941–52.

The author's address is:

New York Academy of Medicine
1216 Fifth Avenue
New York, New York 10029
E-mail: jbarondess@nyam.org