Senate Testimony

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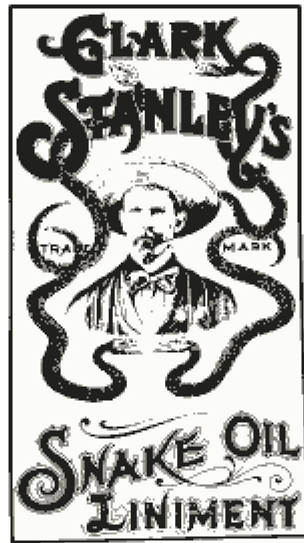

1) American medicine in the 19th Century offered a broad range of philosophies and practices. Nearly all of them are forgotten now and, by and large, it is good that we have abandoned them.

2) The turning point came with the publication of the "Flexner Report" in 1910. This book-length analysis of medical practice in America concluded with the following recommendations:

   a. Admission to a medical school should require, at minimum, a high school diploma and at least two years of college or university study, primarily devoted to basic science.
   b. The length of medical education required to last four years.
   c. Proprietary medical schools should either close or be incorporated into existing universities.
   d. Medical schools should appoint full-time clinical professors, who would be barred from all but charity practice, in the interest of teaching.

3) These changes led to the rise of the modern profession of medicine. It raised the "allopathic" medical philosophy above all others and put most competing philosophies out of business. The kindly hometown medical doctor became an American legend.

4) After World War Two, an unprecedented world historical boom in medical technology empowered the medical profession. New medicines, new technologies and new procedures transformed medical practice and raised the power and prestige of American doctors to unprecedented heights. There is a joke that every 20th medical student remembers...

Q: What is the difference between God and a surgeon?

A: God does not think he's a surgeon.

5) We are now entering another transformational era in health and health care. The relationship between patients and "health care providers" is being remade. The old ideal of, "Doctor Knows Best" is giving way to a new, and much more equal, partnership between patient and practitioner.

a. Patients are seeking, finding and using health information from a wide variety of sources. The consumer information revolution is alive and well in the health care arena.
b. Patients and doctors are spending more time dealing with the ongoing management of chronic illnesses and less time dealing with the immediate treatment of acute illnesses and injuries. This trend will accelerate as our society ages.
c. Patients and medical professionals face an increasingly complex network of sub-specialists and advanced treatment options that are both powerfully effective and very confusing.

6) I think the best new model for the emerging patient-provider relationship is "patient-centeredness." This philosophy of care places the individual patient at the center of the decision-making matrix. It encourages the exchange of information in both directions.

Providers who adopt this framework soon find themselves working to develop new models, new systems and new approaches to previously intractable problems. These new models include:

a. The idea of a "Medical Home" offers us a way to manage increased complexity and confusion of the existing jumble of specialists and sub-specialists. http://en.wikipedia.org/wiki/Medical_home
b. The "Planetree" model shines a light on person-centered practice in acute care environments. http://en.wikipedia.org/wiki/Planetree_Alliance
c. The "Eden Alternative" provides a pathway for existing long-term care organizations to alter their organizations and environments in ways that "bring decision making as close to the elders as possible. http://edenalt.org

d. The "Green House" provides a radically "person-centered" approach to the long-term care needs of people who would otherwise be required to live in nursing homes. It offers a developmental approach to aging and care that adapts the daily routine to the needs of the elders rather than requiring the elders to adapt to an institution's daily routine.

http://www.ncbcapitalimpact.org/default.aspx?id=146

7) "Person-centered" care is an authentic grassroots movement that has the power to unite patients and providers in a shared effort to experience how we interact with the health care system. So what can the federal government do to drive innovation forward? Here are my suggestions:

a. Weave person-centeredness into the reimbursement system.

   i. The current system provides outsize financial rewards to people and organizations that concentrate heavily on technology-centered or sub-specialty-oriented care.

   ii. We are entering a historical period where the greatest advances in our health and well-being are going to come from creative new ways to use the technology and knowledge we already have.

   iii. Our reimbursement system is based on an outdated "input-based" approach to health care.

b. Encourage the development and testing of responsible, evidence-based innovations in new models, work roles and funding strategies.

   i. We have supported biomedical research and that support has yielded life saving drugs. Now it is time to fund health care system research.

   ii. Fear of regulatory sanction deters some people and organization

from pursuing new "patient-centered" models. I do not favor a regulatory rollback. I do favor improved mechanisms for understanding and responding to that fear.

iii. Invest in developing the leaders who will take our entire health care system into a "person centered" future.

c. Come to terms with the fact that our health care system is heavily biased toward the immediate treatment of acute illnesses and injuries and that the bias needs to be changed so that it favors the ongoing management of chronic conditions. This is the essence of the person-centered reform movement.