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Dedicated to the belief that informed patients will choose the "Best of Health" care available.

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The Quality of Medicine

By John B. Costello, M.D.

Quality Medicine is expertise and service. Expertise is defined as the right diagnosis and the right treatment provided in a manner that is proper and empathetic. Service is that expertise applied in a timely manner, including both acute care and long term continuity-of-care. The purpose of this article will be to examine this definition of the quality of Medicine, and establish it as the foundation of any decisions that will be made on health care in America.

The quality of Medicine is also a function of community standards which vary with the sophistication of the medical providers, the sophistication of the patients, and the communities' financial strength in supporting new technologies.

…the right diagnosis and the right treatment…

Expertise is a function of the doctor's knowledge of disease, sufficient investigation of the ill patient and appropriate treatment. Until recently the only limits on this process were the doctor's education, the patients moral or financial wishes for tests and treatment, and the community's level of medical technology.

In the last five years the third party payers have wanted to limit this process of reaching the right diagnosis and treatment by cost. They are doing this in two ways. The first is by reimbursement befuddlery. This is the delay in paying or the refusal to pay health care claims to either patients or health care providers. The second is through practice guidelines.

There are two kinds of practice guidelines. The first kind of guidelines is recommendations made by a panel of physicians after studies have been done to determine the best diagnostic test or treatment for a particular medical problem. An example is cholesterol screening. This is a good guideline.

The second type of practice guidelines is dangerous to your health. The third party payers are defining medical and surgical practice by rigid algorithms and flow charts designed with little understanding of the uniqueness of disease presentation and response to treatment. They limit the process of diagnosis and treatment to only those practice guidelines that have been approved.

Getting to the right diagnosis and treatment is made more difficult. The process which formerly only required the doctor's knowledge, the patients approval, and the community's technology now requires the burdensome approval of the bureaucratic third party payers.

This has been done in the name of "quality". However, the real purpose of these guidelines is to reduce the number of diagnostic and therapeutic procedures ordered and thereby reduce their costs. Worse, these guidelines will fix obsolete diagnostic and therapeutic procedures for budgetary convenience.

These guidelines also denigrate the entire process of developing new diagnostic tools and therapies. They are an insult to the many dedicated physicians and scientists over the last two centuries.

Journals such as the British Medical Journal, Lancet and The New England Medical Journal have the finest written tradition of the scientific method in the English speaking countries, with over 150 years of ongoing "practice guidelines". Do you really expect the government and the insurance companies to keep their guidelines as up to date as the leading edge standards of these medical journals?

Witness the current cost and struggle it is to bring a new drug to market. The length of time it would take to change an approved "practice guideline" is mind boggling!

Once these rigid guidelines are in place, the next step will be to allow other health care providers, i.e. medical technicians, nurse practitioners, or physician assistants other than physicians to perform these duties, based on the premise that medical diagnosis and treatment is 'cookbook'. Anybody can diagnose and treat with a minimum of training and at considerable cost savings. There will

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be more on this third party payer behavior in another "Best of Health" Quarterly.

One development that has been good for the "quality" of medicine has been the requirement for continuing medical education. This is a need that has grown out of the rapid technological advancements in medicine and insures the physician knowledge base stays current. Another positive development has been the patients' increase in awareness of diseases and treatment and their more informed participation in the decisions on therapy.

…in a manner that is proper and empathetic…

To continue the discussion, expertise requires "a manner that is proper and empathetic." Proper in this context means honest and ethical. This arises from the original Hippocrates Oath which I have provided on page 4. It is worth perusing.

Empathy means the capacity for one to participate in or experience another's feelings, ideas and emotions. An empathetic relationship does not develop overnight. It is based on ongoing interaction of the doctor and patient. Quality in medical care preserves this doctor patient relationship.

…in a timely manner, including both acute care and long term continuity-of-care…

Service is expertise applied "...in a timely manner, including both acute and long term continuity-of-care..." This is the aspect of "quality" that the Third party payers pretend does not exist. Medicine is a service! They want you to think it is a product!

To clarify the timeliness of acute care an analogy will be utilized. At one time or another we have all sat in a restaurant wondering when the meal was going to be served. We all marvel at the service of restaurants like McDonald's. Imagine your surgeon providing the service of the bad restaurant when it was time to take your appendix out. "Call my lawyer!" you would scream. (I wish I could have done that at some restaurants!)

Medicine is people serving people. Good service requires incentives for the person providing the service. When return on effort is restricted and the lazy physician earns as much as the physician who put in that little extra, the physician trying harder quits and "quality" suffers. Then patients suffer.

…Medicine is a service…

If you have any doubts about this aspect of human nature, the next time you are at a restaurant indicate to your waiter that you don't believe in big tips and watch how your service deteriorates. Or ask yourself the question, "Would I rather wait for my regular doctor or for a doctor at the Veterans Hospital?"

The timeliness of "long term continuity-of-care" is an even more important aspect of the "quality" of medical care in that it is an integral aspect of the physician patient relationship. Continuity-of-care is more than a copy of the patient's medical record. It is getting to know the patient and the patient getting to know the physician. Eventually trust develops to the point that difficult issues can be discussed with confidence that help will be forthcoming.

Also a knowledge of the patient is built up in the physicians mind that transcends the medical record. The patient has a problem. The treatment is obvious and the patients tolerance for it is already "built in" to the physicians therapy. This relationship of interactive understanding takes years to develop. The older physicians know all about this. It is why they never kept detailed records. They knew their patients.

…a function of community standards…

Quality is also dependent on community standards and its financial strength. Communities make two decisions in health care. Does the diagnostic or therapeutic procedure help? Is it affordable? The third party payers seek to restrict the patients care further by asking is it affordable for this particular patient based on their level of insurance coverage? This is wrong to do. Whether a test is affordable should be a question asked only at the level of the community, not the individual.

If the community standard is a CAT scan for a particular problem then the patient at the public hospital should get the same test as the patient in a private hospital. The level of service will be different but the diagnosis and treatment are the same. For example, the patient at the public hospital may have to wait three hours before and after his test in a drafty hall with only his hospital gown on, but he gets the test.

The sophistication of the providers and patients also determines care. The physicians of Tibet won't be providing the same care as the physicians in Boston and the patients expectations will be similarly different.

Thank you for reading this article all the way through. It is our hope that you, the patient, apply this definition of quality of medicine when thinking about medical care for yourself or your loved ones. Don't confuse quality, expertise and service with cost in medical care decisions.



Health Care Players' Motives

By John B. Costello, M.D.

As every Perry Mason episode reiterates, find the motive behind human action and you find the truth.

When you hear someone discussing quality in Medicine, it is wise to ask who is discussing the issue and what is their motive for being in the health care field. A summary of the major players in health care is shown at right.

Only four players have an interest in quality, the patient, the doctor, the employers and the hospitals.

The patients have the only "pure" interest in quality. After reading the other article in this bulletin one should be more educated as to what should be looked for when defining the "quality of medicine."

The physicians have the next strongest desire for quality. Physicians want quality because 1) good results make for happy patients and referrals; 2) bad results make for unhappy patients and no referrals; 3) good results are intellectually and emotionally fulfilling; 4) providing the latest treatment is the best psychological defense against the futility of treatment when the patient dies.

Three things can deteriorate the physicians desire for quality: 1) inadequate pay for services; 2) patients that are impolite, unreasonable or dishonest; and 3) malpractice accusations and/or dishonest Review Boards.

The employers want quality for several reasons. They want their employees' health care insurance benefits to satisfy their employees and insure their employees' continued ability to work. Employers look on employees as assets that they want to maintain. Employers lose their enthusiasm for quality when health insurance premiums cut into company profit.

The hospitals want quality because good results for patients using their services is good for business. Hospitals are not interested in quality when it cuts into their profits. There will be no interest in quality by hospitals when they no longer can make a profit.

There are four players not interested in quality. Their motive for being in the health care field is either to make money or control people by controlling monies.

The first is the insurance companies. Their goal is to make money by insuring the most people with the least medical risk and, when pressed, to pay out the least monies for medical claims. They have no interest in quality and seek to maximize the shareholders return on investment. They will not even touch the area of medical quality of care for fear that they would become liable in malpractice suits.

The second is the pharmaceutical companies. They are strictly in the health care field for the money.When there is no more financial reward to drive research and development of drugs for humans, there will be no more new drugs.

The third is the universities. They have no interest in quality. They seek only funds, as government grants, as benefactors' gifts and through special contracts with the insurance companies. They have no interest in quality as their patient populations are usually captured by location, by cost of new therapies and by therapeutic restrictions on the surrounding community. They seek control by determining practice guidelines of the more dangerous kind, as described in the accompanying article. They seek control by determining who gets what residency programs, hospital beds and ancillary services.

The fourth is the government. The government is in health care strictly for control, financial and social. Financial control by the collection of taxes and then by maldistribution of monies when patients need medical service. This group is the most dangerous to your health because it does not keep in touch with scientific, economic or financial realities. Government has no interest in quality. An example of this was the refusal by Medicare to pay for routine mammograms. Fortunately, this finally was changed effective January 1, 1991, three years after studies confirmed the benefit of routine mammograms.

At the present time, the group of players least interested in quality in medicine are the ones deciding the fate of medical care in America. The motives for government, insurance companies and universities being in medicine are not in the patient's best interests. Government and insurance companies should not be deciding the future of health care for America.

PLAYER	MOTIVE
Patient	Quality; Least cost.
Physician	Quality; Reasonable pay; Intellectual & Emotional satisfaction.
Employer	Limited quality; Cheapest health care.
Hospitals	Limited quality; Maximize profit.
Universities	Maximize profit; Control, both social and financial; Cheapest health care.
Government	Cheapest health care; Control, both social and financial.
Insurance Companies	Maximize profit; Cheapest health care.
Pharmaceutical Companies	Maximize profit.

The best player to decide what medical care should be is the patient. The people should choose by national referendum. Physicians should be advising the patients on this issue as we do for illness.

Thank you for reading this article all the way through. It is our hope that you, the patient, will ask yourself two questions when discussing the quality of medicine: "Who do you want deciding the quality of medical care you will receive?" and "What are the motives of the person, company or agency discussing/ deciding these issues?"



The Hippocratic Oath

translated by C. Lilian Temkin

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art-if they desire to learn it-without fee or covenant; to give a share of precepts and oral instruction and all other learning to my sons and the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.



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