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Health Care Quality: Have We Forgotten Caring?

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FINALLY, A LOUD CALL FOR QUALITY

Every health care pundit and, more surprising, every legislator and congressperson now seem to agree that guidelines for assuring quality in health care must be an essential part of any health care reform package. Even at the state level, few talk only of cutting costs or expanding access.

As in all industry, the commitment to quality in health care was never really a force by itself. In the long years after the oil embargo of 1973 signaled a change in America's place in the global economy, pressure to contain costs has driven the quality revolution. Health care is no exception. Still, it was quite some time before widespread questioning of the quality of our health care began. We tried first to control costs and expand access without implicating quality. With the acknowledgment that most cost containment efforts fail to make a significant dent in the nation's health care bill, we were forced to look straight at quality as a means of making our health care spending decisions more rational.

DEFINING QUALITY

The push to assess quality is taking place on a number of fronts, and "quality" has as many definitions as there are venues of investigation. The problem with assessing quality is that everyone—clinicians, administrators, payers, regulators, and patients—has a different definition of it. In many patients' minds, quality is confused with high, often unrealistic, expectations. In payers' minds, it is often confused with the fewest and least expensive services. In providers' minds, it is often confused with the most and costliest services. We lack, and desperately need, a social and political consensus that recognizes that quality is not synonymous with quantity or cost or the lack thereof.

PRACTICE PARAMETERS: CODIFYING THE SCIENCE OF MEDICINE

The physician community has responded by advocating and drawing up practice parameters. These are emphatically guidelines—and not standards—that give physicians a better sense of which treatments have been shown to work for specific maladies. The hope is that parameters will help reduce the number of physicians whose practice patterns are outside the mainstream. Physicians fear that, in the name of quality, the profession will be reduced to "cookbook medicine," tight strictures on what they can do that will prevent them from responding sufficiently to individual patients' needs. Parameters are their compromise offering. They are the professional consensus on science that frees the physician to pursue the art of healing.

Practice parameters are certainly a welcome attempt to address unacceptably high variations in patterns of care among physicians. They do present problems, however, in encouraging better quality care. While physicians fear that practice parameters may push the profession down the slippery slope that leads to absolute standards and cookbook medicine, many persons outside the physician community fear exactly the opposite: that the parameters will be far too general to have any significant effect on improving the quality and, incidentally, reducing the cost of health care. Granted, several studies have shown that parameters have reduced health care costs associated with certain procedures. Nevertheless, if guidelines are drawn so that

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the overwhelming majority of physicians can continue to practice as they always have, they will do little to reduce costly unnecessary care.

PRACTICE PARAMETERS AND THE ART OF MEDICINE

Another reservation about practice parameters is mentioned much less often. In his recently published *The Nature of Suffering and the Goals of Medicine*, Eric Cassell, M.D., argues that, contrary to the contention of many in the profession, "physicians *depend too heavily on recipes for diagnosing and treating disease* [emphasis added] and they ignore the art of medicine—understanding patients, how they live, what they think, and how they should be treated." Dr. Cassell believes that physicians must better understand that they must treat not only disease but also suffering, and two patients with the very same disease may have a completely different psychological response to it. "The way a doctor treats two distinct patients involves more than technical competence and medical knowledge. The physician must provide empathetic support," he explains.

This is not a new perspective; what is new is looking at it in the context of practice parameters. Perhaps physicians, in pushing for parameters, and other health policy makers, in pushing for other measurements of quality, are not viewing quality in the broadest context. Perhaps physicians' problems have something to do with bedside manner, which will never appear in a practice parameter. Perhaps it should.

PRACTICE PARAMETERS AND MEDICAL LIABILITY

Quality of health care, especially physicians' attention to the subjective needs of sick people, has largely been missing from recent liability reform discussions, despite the fact that many believe that closer relationships between physicians and their patients would reduce the number of lawsuits filed. (A patient is much less likely to sue a person s/he knows, likes, and trusts.) True, providers and attorneys have argued back and forth about the value and harm to patients of reform proposals. Certainly, there is evidence that access to health care for the poor has been hurt by high liability premiums, and access is a quality of care issue.

No one, however, wants to talk much about liability reform and whether it improves the quality of care for patients who *already* have access. Yes, bills reported out of the special Michigan Senate Committee on Affordable Health Care would set up pilot programs for physicians in certain specialties who, by agreeing to follow certain practice parameters, would be allowed to use the parameters as a positive defense in a medical liability case. But there is something disheartening about introducing practice parameters primarily to protect physicians **against** patients; they have been developed, supposedly, to improve the quality of care physicians give to patients. Will parameters only drive another wedge between physician and patient?

CARING AND QUALITY

Clearly, we need a health care system that encourages closer relationships between physicians and patients. This is hardly the fault of physicians alone. At present, ours only encourages antagonism between those who pay for health care and those who provide it; too often, patients only get in the way. Yes, we need to contain costs; we need research on which treatments work best for which patients. But we also need to remember the "caring" in health care, the concern for the patient's well-being that is supposed to drive the system. Often, this has little to do with science or research or higher copays and deductibles. Let's not forget all the meanings of quality.