Revolution in Practice Management: A New Kind of Drudgery

I read with interest the article by Ramsey[1] in the September issue of the ARCHIVES on the coming revolution in practice management. Ramsey describes outcomes management technology, medical informatics, and quality management as the technologies that will " . . . liberate those physicians who apply them from much of the drudgery of practice today" and provide them with tools that will empower them to improve their performance. While I welcome the information Ramsey provides on the direction of practice management and the "emerging health care system," I find his enthusiasm for it disturbing and unrealistic. I believe that the kind of health care system he describes cannot bring liberation or empowerment to anyone but a very few at the highest reaches of the new management for this system.

Ramsey looks forward to a less hierarchical system in medicine in which patients take a more active role in decision making and physicians practice corporately and are integrated into the new medical system. I agree that this will make the patient and physician more equal, but disagree that it will give either one any more power or freedom. When goals are set by management (whether it includes physicians or not) and management has the power to monitor physician (or patient) behavior down to very small details via computers and profiling systems, then neither physicians nor patients have been empowered, but rather power has passed from them to others. We will have changed from a system in which power is widely distributed to one in which power is centralized via computer profiling and corporate (or government) goal setting. There is no advantage here.

I suppose the thing that bothers me most about this article is its appeal to physicians' desire for more money. I am troubled by the fact that every proposal for change in medical practice found in either the general or medical literature finds its final justification in its pronouncement that money will be saved or gained by somebody. Physicians and others interested in improving health care in this country, whether conservative, liberal, socialist, libertarian, or religious in their viewpoints, all ultimately return to this one point as their final and most profound argument: The country (or physicians, patients, insurance companies, or the new health care managers) will save (or make) more money with this plan. I believe all these have missed the most important point.

Our professional calling is to the service of the sick and suffering. The failure to keep this in mind as our first priority is degrading us all as physicians and human beings. In saying this I do not want to give the impression that the outrageous cost of health care in this country is not a problem or that it can be solved by simply rearranging our stated priorities. My point is that we cannot cure our poisoned health care system by prescribing more poison. Our profit-oriented health care system cannot be improved by trying to apply a refocused profit motive to it. The change needed is more fundamental than that.

We should not shy away from this task simply because it is a difficult one. Physicians and journals like this one must have the courage to confront the need for fundamental change head-on. If we do not, others will continue to change medicine for us and rob us of our professional calling and our souls all at once.

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1. Ramsey C. Revolution in real time: physician practice management in the 21st century. *Arch Fam Med.* 1992;1:139-148.

In reply

In his thoughtful letter concerning my article, Moore raises two important issues about the future of primary care practice. The first issue concerns the relationship between information and power. The collected wisdom is that he who has information has power. Presently, third parties have the information about the physician's practice. Whether physicians like it or not, insurers and the government have a great deal more information about individual physician practices (including the overall patterns of care and the costs of care of patients) than do physicians.

For example, these groups have built data files that show the timing and sequence of all medical procedures, medications, and hospitalizations for a given patient either during a period of 1 year or for a defined episode of care or illness. Comparing the different patterns of patient care for the same diagnoses gives these third parties information on the cost-efficiency and practice patterns of individual physicians. Some third parties even collect direct patient

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satisfaction information from their members and include it in their overall assessment. The databases are detailed enough to reveal that the variations in resource use are due to such variables as excessive use (or underuse) of laboratory tests or consultants (specialists) or use of a more (or less) expensive drug. To me, this is powerful stuff.

The point of my article is that if the physician chooses, he or she will be able to collect and manipulate information in the practice environment that is far more powerful than any third party could assemble. This will not stop "outsiders" from monitoring physician practice but it will give the physician better access to and control over the information about his or her practice. Giving employees access to information destroys the hierarchy in most organizations and liberates them to do a better job of solving problems.[1] Walter Wriston summarized it best: "The Orwellian vision of Big Brother watching the citizen has been stood on its head, and it is the citizen who is watching Big Brother."[2] Thus, experience indicates that using information technology in medical practice will result in a reorganization of the system to one in which power is much more widely distributed, a situation very different from the current system in which power is highly centralized.

The second issue Moore raises, on which we both agree, is the need for fundamental transformation of the health care system. My position is that the way to improve the health care system to is give family physicians, ie, personal physicians, the tools to better serve the individual needs of their patients.

This involves ways to collect and use information on patient preferences, outcomes, effectiveness of treatments and consultants' actions, and technologic procedures to do a better job of taking care of individual patients. Family physicians must find better ways to present information about treatment options to patients to allow them to make more informed decisions about their care. Individual physicians must understand why the differences in their practice patterns exist and change their methods of operation if the variation is not justified. Transformation of the health care system must begin at the grass-roots level, ie, the family physician–patient level. Family physicians and their patients have the power to drive the transformation of the health care system if they choose to collect, analyze, and use information that documents their accomplishments and contributions.

Moore voices concern that the motivation and justification for the use of technology is money. Such a conclusion was not my intent. Money is, however, one factor that must be considered because change often requires new equipment and/or new technology, which impact practice operating costs. Collecting additional information and entering it into a computer system also increases costs.

It has been my experience as a practice consultant that physicians always want to know how to finance the changes. The purpose of discussing money in the context of real-time revolution is to raise the possibility of financing the potential changes through increased efficiency and/or productivity made possible by the new technology.

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1. Gilder G. *Microcosm: The Quantum Revolution in Economics and Technology*. New York, NY: Simon & Schuster; 1989.
2. Wriston WB. *The Twilight of Sovereignty*. New York, NY: Charles Scribner's Sons; 1992.

Welcome to the Family, More Than 'Referralists'

I would like to tell you how disappointed I was with the Editorial by John Lee Clowe, MD, that opened the first issue of the ARCHIVES.[1] Clowe's comments promulgate many myths about the specialty of family practice and seem to echo a philosophy that may be the hopes of organized medicine embodied in the American Medical Association, but certainly is not the vision we as family physicians have for our patients and ourselves.

The role of family physician as patient advocate is unquestionable. However, continued emphasis on family physicians as "case managers," medical social workers, and interpreters of the words and actions of other specialties is overemphasized and overstated. Perhaps some feel that by relegating family physicians to the role of referralists they will ensure a continued flow of patients through the family physician's office to receive services from other specialists.

Clowe should be made aware that family physicians do not wish "further curtailment" of some aspects of their practice. Particularly in the case of obstetrics, it is clear that more family physicians and not fewer need to be involved in the delivery of babies. Studies have confirmed that it is not the cost of malpractice insurance that drives family physicians from obstetrics, but rather issues of lifestyle and in many cases the inability to develop an appropriate relationship with obstetric consultants.

The scope of practice of family physicians is expanding. Inclusion of such procedures in our practices as cardiac stress testing, colposcopy, loop electrosurgical excision procedure, and endoscopic services such as flexible sigmoidoscopy and nasorhinoscopy enhance our ability to provide cost-effective care to our patients. Continuance of our ability to maintain hospital privileges is also vital to our specialty.

It is interesting that Clowe identifies the Resource-Based Relative Value Scale and "increased focus on managed care" as areas where the AMA and family physicians need to work together. I suspect that what he really means is that the AMA's Council on Long Range Planning and Development recognizes that fam-

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