

Essays and Commentaries

Editor's Note: The editors of *Family Medicine* invite submission of manuscripts to add to this "Future Vision" series. Manuscripts should be 1,000–1,800 words long, include "future vision" in the title, and should be submitted to manuscripts@stfm.org.

Future Vision: Is Family Medicine Ready for Patient-directed Care?

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A growing number of Americans will soon have a Web-based personal medical home with connectedness to their chosen providers of care. The personal health record will become integrated with the electronic health record. Like other services on the Internet, patients will be able to direct much of their health care using clinical guidelines, such as prevention, chronic illness care, behavior change, and arrangement for minor acute care. Physician control and autonomy will give way to greater patient control over their care, a major culture change in medicine away from paternalism. While the personal family physician will continue as a primary caregiver, there will be a shift toward greater patient involvement in the coordination of care. Family medicine educators should begin now to educate medical students and residents for this new model of care.

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In 2012, what will an average American be able to do when they log into their Web-based personal medical home? Will the Internet fulfill the dream of patient self-management? What will become of the personal family physician? How should we train family physicians when more and more patients begin directing their own care?

Is the Medical Home Model Really Patient Centered?

The Medical Home Model has captured the hopes of primary care physicians who are yearning for a better day. After a prolonged period of decline, primary care is poised for a comeback if better reimbursement and greater medical student interest can be accomplished. A rational and affordable health care system depends on a

healthy foundation of primary care. The Medical Home Model, with its patient-centered coordination of care, seems to be just the right concept on which to pin the hopes of primary care.

Primary care enjoyed a period of rapid growth in the 1990s, riding the wave of managed care. It was a period of cost reduction based on primary care physicians serving as gatekeepers. The gatekeeper model was doomed to fail, however, among an American public that demands choice over where it gets health care. As the popularity of managed care waned, so went primary care. In cynical terms, one might say that today's medical home model is the gatekeeper over again with nicer words. They share the strategy of asking patients to have their comprehensive care coordinated in a single primary care environment, though recent innovations in primary care coupled with the changing demographics of an aging population offer hope that

the medical home will not suffer the fate of gatekeepers. Coordinated chronic illness care, team approaches, and health information technology all combine to offer new processes of care not understood or available 15 years ago.

In 2007, the major primary care organizations agreed on a set of guiding principles for the patient-centered medical home.¹ These describe the innovations necessary in primary care to achieve improved coordination of care and better outcomes. All the principles are progressive except one that sticks out as a commitment to the past—physician-directed care. Apparently, the crafters of these principles did not want physicians to lose any control over patient care.

Is this Medical Home Model care, with its commitment to physician-directed care, really patient centered? It depends on what you mean by patient-centered care. To some, being patient centered means that you focus on the patient, not

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just the disease. Another view of being patient centered is to put the patient on the care team, even at the center of the team.² In the Institute of Medicine report *Crossing the Quality Chasm*, patient centered is one of the six aims for quality health care, and the report defines it as care that “encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient.”³ Shared decision making has emerged as a care model, especially when the evidence is not completely clear about what tests and treatments are preferred, such as with breast or prostate cancer screening and treatment. These concepts allow for patient centeredness while preserving the traditional physician control over medical practice. That may change, even radically, as more health care moves onto the Internet.

The Internet Releases the Power of Patient Self Management

The Internet makes it possible to give patients more control over their care and challenges the concept of physician-directed care. When patients have their personal health records connected to their chosen providers of care through Web-based personal medical homes, what is to stop them from coordinating some of their own care? Physicians who think they will direct patient care in the future might reflect on what has happened to personal bankers, stockbrokers, and travel agents. Health care has had a delayed reaction to this revolution in consumer control—a degree of control that would have been unimaginable a few decades ago.

Of course, some health care will always be physician directed. Physicians will always be in charge of providing care for trauma, surgical emergencies, and major acute medical problems. When patients become acutely ill, whether with a myocardial infarction or acute appendicitis, they need and desire

a physician to take charge. Indeed, for some complex medical and surgical problems, even arrogance on the part of physicians has its place.⁴ In complex health and illness matters, an objective professional physician is a source of comfort and care, and for many patients, having a personal family physician is desirable even if they are able to coordinate much of the care. Other patients, especially those with limited education or inadequate literacy, may always need to rely on a physician and health care team to direct their care.

Outside of the aforementioned exceptions (acute care of major illnesses, trauma, and emergencies and patients incapable of coordinating their own care), there is a question about whether the physician should still be in charge. Ed Wagner developed the chronic care model based on informed and activated patients interacting with a prepared and proactive medical team.⁵ The relationship is symmetric, with the control of care equally shared. Patients are asked to become experts themselves, to develop an understanding of their chronic illnesses that matches or perhaps exceeds that of their physician. With the Internet, all knowledge becomes available for free, and learning happens rapidly. Patients, supported by their families and friends, only have their own problems to learn about.

This type of patient self-management has been studied for more than a decade, and the evidence for better control of chronic illnesses is impressive.⁶⁻¹⁰ David Sobel, medical director at Kaiser Permanente Northern California, has found that the greater the degree of patient self management, the better the outcomes. Conversely, dependence on the physician is detrimental to the management of chronic illness.¹¹ Indeed, Kaiser has launched a Web platform where its members may directly access recommended care services. Why should a physician stand in the way of a patient getting

recommended preventive services or tests for the monitoring of their chronic illness? If what should be done is known, why require a visit to a physician? As patients become knowledgeable and have the power to direct aspects of their care, the primary care physician becomes an unnecessary “middleman.” Rather, the primary care physician should become a resource for the patient—a consultant or coach—rather than a gatekeeper through which the patient must go to receive routine preventive and chronic illness care.

Patient-directed care does not, of course, mean that the care team backs off and leaves the patient unattended. Patients should not be alone making sure that they get their recommended services. For quality outcomes to occur in patient-directed care, the care team is proactive in communicating with the patient about services with the patient and works hard to ensure that timely optimal care is received.

What Care Will Be Physician Directed?

If patients will be orchestrating much of their own care, what care will be directed by physicians? The answer is seen in the stratification of primary care services currently being undertaken by large health care systems like Kaiser, which is organizing health care around five distinct areas: prevention, chronic illness care, maternal and infant care, trauma and major acute care, and minor acute care.¹² If those are in different places in the health care delivery system, where is primary care and family medicine? Primary care becomes the integration of ongoing care—prevention, chronic illness, minor acute illness—all best done from a biopsychosocial perspective. Family medicine also provides pregnancy care and early infant care. Rural physicians continue to provide trauma and major acute care. But, the specific role

of family physicians in this new delivery system is not the same as family medicine of today.

What Care Will Be Patient Directed?

What about the patient? What services will the informed and activated patient, armed with a Web-based medical home, be capable of obtaining directly? The obvious ones are recommended preventive services; self-management of common chronic illnesses such as diabetes, hypertension, and asthma; behavior change such as smoking cessation and weight loss; and arranging for minor acute care. The family physician becomes a resource serving many roles desired by the patient—provider and coordinator of care, coach, or consultant—helping with tough decisions like what to do for colon, breast, and prostate cancer screening and treatment. Even the prenatal care schedule could be managed by activated patients.

This is not about putting patients in charge of what they do not want to do or of what they are unable to do. Rather, it is about patients being enabled to play an active role in their care as they access all the resources available to them and seek care within recommended clinical guidelines. Who will want to sit in a crowded waiting room to have a brief encounter with a physician when they can find out on their own what needs to be done? When visits become selective encounters for issues about which patients can't find answers, rather than the sole source of care, visits should all happen on time in unhurried and less crowded environments.

Major steps in the direction of patient-directed care have already been made by Kaiser's Health Connect platform and Geisinger's Personal Health Navigator.¹³ Microsoft with HealthVault and Google Health are partnering with major groups such as Mayo Clinic and Cleveland Clinic, and these organizations

have the vision of revolutionizing health care around patient-directed services. Dossia has been formed by a consortium of major employers, and even Wal-Mart employees have their personal health records and will soon be directing their care with willing providers.

Does this mean that patients will get any care they want? Of course not, especially care for which they do not directly pay. Patient-directed care would operate under recognized clinical guidelines and represent care the provider and payer would want the patient to have. Everything else would come through communication to agree on appropriate services.

Training Family Physicians for Patient-directed Care

The service model of most industries has changed radically in the age of the Internet. That is now happening in health care, too. The change process is still early, but the horse is out of the barn. Physicians and other caregivers need to adjust to patients having more control over their care. This is a culture change for a health care system that is currently very paternalistic. Physician control and autonomy arose during the 19th and 20th centuries, but this approach will have to change.¹⁴ Health care has had its social transformations before and will have one again in the 21st century.

Unfortunately, most clinical settings in medical education are also highly paternalistic. From the day of the white coat ceremony, medical students becoming physicians are taught to respect and "take care" of the patient. Professional respect in medicine is fine, but the message of control begins early. The boundary between health care professionals and the public forms and becomes two distinct worlds, and patients have limited access to communicating about their own care. While this separation may persist in major acute hospitals, it will erode in chronic care and prevention. Health

caregivers, including physicians, will need to learn to serve patients who have much greater control over their care.

Patient-directed care will be a culture change for medicine. It will not happen overnight, and strata of the population will move to it at different rates. There will always be a segment of the population that does not want to be bothered with or is afraid of their health care decisions and that is happy to have physicians direct the care. There will always be people who want to be taken care of and who desire paternalism or maternalism from physicians. There will always be tensions between what patients want and their evidence-based needs and tensions among payers, providers, and recipients of care. Health care is messy, which is one reason why it has been slow to change its processes. But, the need for family physicians to be chameleons, able to change styles to adapt to the patient, is everlasting.

The Role of Family Medicine

Family medicine, with its emphasis on patient-centered communication, is well positioned for this transition. However, loss of control of patient care will be threatening to many family physicians. The personality of our specialty may undergo a shift much like it did in the transition of general practice to family medicine.

That shift needs to be driven by medical education. Family medicine educators should prepare new scripts for role modeling and additional training for simulated patients. Paternalistic tendencies will need to be exposed and addressed in both teachers and learners. Physician-directed electronic health records should be integrated with patient-directed personal health records through secure portals that become new communication platforms for care coordination. Are we prepared for a single shared health record controlled largely

by the patient? Are we reducing the toxicity of dependence and releasing the power of patient self-management? We all strive to be healers, and our healing skills are shifting more to what we always strived to do, helping patients take care of themselves.

The Future of Family Medicine project along with TransforMED has sought to define the personal physician for future practice. Green et al, in a commentary on preparing the personal physician for practice (P4) papers evokes the time-honored perspective of the personal physician by T.F. Fox in the 1960s (apologies for the male gender):¹⁵

The doctor we have in mind . . . is looking after people as people and not as problems. He is what our grandfathers called ‘my medical attendant’ or ‘my personal physician;’ and his function is to meet what is really the primary medical need. A person in difficulties wants in the first place the help of another person on whom he can rely as a friend—someone with knowledge of what is feasible but also with good judgment on what is desirable in the particular circumstances, and an understanding of what the circumstances are. The more complex medicine becomes, the stronger are the reasons why everyone should have a personal

doctor who will take continuous responsibility for him, and, knowing how he lives, will keep things in proportion—protecting him, if need be, from the zealous specialist....¹⁶

Dr Fox could not have imagined patients with Web-based personal medical homes directing much of their care. He would argue for the continuation of the personal family physician. A great class discussion would be an analysis of the truth versus paternalism in this statement and the delicate navigation in store for family medicine.

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