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Health system reform and the critical care practitioner

Russell C. Raphaely, MD, FCCM

Polls sponsored by Democratic and Republican organizations indicate that U.S. inhabitants want protection from financial hardship caused by the cost of medical treatment of illness and injury. Although 83% of U.S. inhabitants possess health insurance, mostly through their employer, they fear that loss or change of their job will leave them uninsured, or the premiums for the insurance will escalate to amounts they no longer can afford.

A recent survey conducted by the Public Agenda Foundation, in conjunction with the Employee Benefit Research Institute and the Gallup polls organization (1), discovered that the U.S. public blames unnecessary tests, overpaid doctors, wasteful hospitals, profiteering drug companies, and greedy malpractice lawyers for high healthcare costs.

By a 2 to 1 margin, 2,000 people from all parts of the country, who were included in a Kaiser Family Foundation and Commonwealth Fund-sponsored national survey performed in 1992 by Louis Harris and Associates (2), want the government rather than the private sector to assume the role of controlling costs. Sixty-two percent compared with 30% preferred the federal government in this role to state authorities. Three quarters of these individuals want this control to include the setting of prices for health insurance premiums, prescription drugs, and hospital and physician charges. Fifty-five percent of these respondents expressed an "interest" in medical care plans that limit choice of doctors in return for a reduction in their out-of-pocket payments for services. This same survey indicated that the percentage of individuals who were dissatisfied with their own health care doubled from 13% in 1987 to 26% in 1992.

Democratic party pollster, Celinda Lake, contends that voters will pay more taxes for a healthcare reform that incorporates cost control set by the government (3). These same voters, according to Lake in a recent poll (3), favored price controls over competition and global budgets as a method to control costs. However, focus group participants, when asked what global budgets meant, answered that the United States had to set budgets for other countries, suggesting that the public does not understand the term.

Lawrence D. Brown, PhD, professor and head of the Division of Health Policy and Management of the Columbia University School of Public Health, expects that a centralized budgetary regulation model will emerge from the healthcare reform debate as the mechanism for cost control (4). Patients and payers seem to have embraced it. Top Clinton Administration officials indicate that they favor it. Large physician organizations, including the American Society of Internal Medicine and the American College of Physicians, have incorporated budgetary controls in their reform proposals. Recently, the American Medical Association has softened its opposing position and indicated that the Association will accept negotiated budget predictability.

While cost control ranks high on the priority list for reform, for moral and political reasons, equal access for all U.S. inhabitants to a minimum amount of medical care remains the foremost element in the "holy trinity" of access, cost control, and quality. Two forms of access exist. Comprehensive access enables an individual to receive all care possible. Universal access provides the opportunity for medical care to everyone. Providing both universal and comprehensive access would be prohibitively expensive. Therefore, medical care reform will likely turn to providing, for U.S. citizens and resident aliens, only universal access to care. According to the President's Commission on Securing Access to Health Care, this care should permit individuals to "achieve sufficient welfare, opportunity, information, and evidence of interpersonal concern to facilitate a reasonably full and satisfactory life." Estimates of the costs to achieve universal access range from $45 to $90 billion, with some estimates as high as $150 billion above current federal outlays.

Current information indicates reform plans will emphasize primary care because forceful arguments have been made that the public is dissatisfied and disenchanted with our current system. This system

From the Division of Critical Care Medicine, Children's Hospital of Philadelphia, Philadelphia, PA.

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Address requests for reprints to: Russell C. Raphaely, MD, Division of Critical Care Medicine, Children's Hospital of Philadelphia, 34th Street and Civic Center Boulevard, Philadelphia, PA 19104-4399.

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has been characterized by the media and policy experts as a medical specialty-dominated, biotechnological, hospital-oriented delivery system. Critics claim the public no longer trusts that this system serves them. Richard Wright, in a recent article (5) in the *Journal of the Medical Association*, stated that the biotechnological hospital model of medical care delivery currently in existence regards the conquering of disease through science as the pathway to health. Furthermore, he claimed that persons embracing this current model consider every disease as possessing a single cause and that discreet solutions exist for every medical problem. He further stated that this system serves a decreasing number of fully insured persons, who obtain the majority of their care in an expensive, technologically filled environment.

Wright (5) continued that it is more troublesome that only 20% of medical interventions have proven to be effective and up to 30% of procedures performed in hospitals may be unnecessary. He contended that this system does not cope well with patients suffering the chronic illnesses associated with aging, disease, or injury stemming from unhealthy life-styles, high-risk behaviors, and emotional stress. Rather, Wright believed, a so-called ecological model, which sees health care as a "natural state effected by interrelated factors including access to health care services, human biology, social environment, physical environment, personal life-style and behavior" is gaining the public's favor.

Preventive and primary care occupy a central position in this ecological model. Community-oriented primary care providers accept responsibility for promoting the health status of a community by identifying and resolving its problems. Wright stated that this model is best suited to meeting the nation's current and future healthcare needs.

Policymakers for whom this argument has appeal, find themselves confronted with only 5% of the national health bill going toward prevention. Also, <30% of physicians are available to provide primary care. Policymakers influenced by the argument of Wright and others have proposed legislation to encourage the training of primary care providers and improve payment for primary care.

Regulatory behavior has begun to limit the introduction of new technology into medical practice because new technology is viewed as a major contributing factor to the increasing cost of medical care.

Logic dictates that sound medical reform should achieve a balance between the primary care ecological model and the medical specialty biotechnological hospital-oriented model. These models should complement each other because the public expects both aspects of care to be available. Critical care practitioners must convince healthcare policymakers to fund critical care and thus further the contributions that critical care has made in improving the health of U.S. inhabitants.

David M. Mirvis, MD, in an essay entitled "Physicians' Autonomy—The Relation Between Public and Professional Expectations," published in the May 16, 1993 issue of the *New England Journal of Medicine* (6) stated, "specialized knowledge, public trust, organized professional advocacy and governmental support maintain autonomy, a privilege which the public grants and may therefore, restrict or remove."

Critical care practitioners, credited by organized medicine as possessing specialized knowledge, share with the public an interest in the health of individuals and the community and have an organization, the Society of Critical Care Medicine (SCCM), that helps them gain the public's trust. We welcome lay participation as legitimate social action when considering medical issues that involve evaluative and qualitative judgment. Under these conditions, the healthcare practitioner's opinion may possess no greater validity than the lay person's opinion.

Evidence suggesting that an erosion of the public trust is occurring, however, exists in the creation of the National Practitioner Data Bank, enactment of laws limiting ownership in healthcare facilities by healthcare practitioners, and enforcement of regulations regarding house officers' work hours. To maintain public trust, critical care practitioners must be accountable for critical care, the cost of which is estimated to be 1% to 3% of the gross domestic product, three to four times more expensive than other forms of hospital care, and up to eight times more expensive if respiratory failure occurs and the patient receives mechanical ventilation.

Critical care practitioners can accept accountability only if the authority for decisions related to critical care rests with them. This authority does not exist in many settings today because critical care remains imprecisely defined. This lack of an institutional definition for critical care leads to a reluctance on the part of other practitioners of medical care to grant us authority, and leads to uncertainty among critical care practitioners as to the responsibilities they are expected to assume.

In 1983, 16 biomedical investigators, critical care physicians, other medical specialists, nurses, a biostatistician, and a judge constituted a consensus development panel organized by the National Institutes of Health. They utilized the following definition of critical care medicine: "multidisciplinary,

multiprofessional medical/nursing field concerned with patients who have sustained, or are at risk of sustaining, acutely life-threatening single or multiple organ system failure due to disease or injury. These conditions necessitate prolonged minute-to-minute therapy or observation in an intensive care unit which is capable of providing a high level of intensive therapy in terms of quality and immediacy." With all due respect to this distinguished panel, I contend that this definition fails to describe critical care or to distinguish it from other medical care endeavors. I offer the following descriptions of critical care for your consideration. I encourage discussion and refinement, with the goal of producing more compelling tenets that may emanate from the debate.

Critically ill or injured patients suffer from disorders that disturb the balance of oxygen substrate supply and demand. Critical care involves accessing and manipulating oxygen and substrate supply and demands in order that aerobic bioenergetics are preserved. Critical care professionals, through formal training and experience, possess the requisite knowledge, judgment, attitudes and skills to manage those aspects of patient care directed at balancing oxygen and substrate supply and demand. The qualified critical care physician, in collaboration with nurses, respiratory therapists, and other allied healthcare professionals, provides the timely assessment and initiation or adjustment of therapy to restore and maintain the balance of oxygen and substrate supply and demand.

An agreement that these or other carefully considered alternative statements should be our principles will facilitate accomplishing the following objectives: a) sharpen the focus of critical care practitioners on the pathology and abnormal physiology unique to the critically ill and injured individual, and on the care rendered to that individual; b) enable critical care practitioners to improve our training programs that prepare individuals for careers in critical care medicine; and c) direct investigation to increase knowledge of relevant basic science, applied clinical science, and outcomes of critical care. This broad agenda should enhance our ability to provide quality critical care which, according to the Institute of Medicine, maximizes the likelihood of desired outcomes for individuals and society, is consistent with current and emerging knowledge, and occurs in a humane and respectful manner.

Critical care practitioners will contribute to the healthcare reform goals of assuring universal access, containing costs, and improving the quality of medical care in the United States by possessing the authority to make decisions based on knowledge, skill, and judgment acquired through training and practice. Achieving these healthcare reform goals will be a struggle. Individual demands will clash with societal preferences. However, holding the authority will enable critical care practitioners to have a major role in resolving the conflict between individual and community.

The SCCM's healthcare platform, developed by SCCM's Public Policy Committee, advocates designating the qualified, full-time, hospital-based critical care physician and qualified critical care nurse as the primary providers of critical care. Obtaining this authority will not be easy. Resistance will come from fellow healthcare practitioners, some of whom simply disagree that the trained, practiced, and committed critical care practitioner is the best-suited physician to manage the disturbances that I have suggested characterize the critically ill or injured patient. Critical care practitioners must overcome this obstacle by possessing the courage to argue persuasively and respectfully for this cause. Access for all critically ill and injured individuals—who choose to receive critical care therapy and for whom critical care therapy is appropriate—to efficient high-quality care depends on critical care practitioners of the SCCM possessing the authority for decision-making and accepting accountability for medical care in which they are experts.

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Society of Critical Care Medicine's

Vision for Critical Care

SCCM envisions a health system
in which all critically ill and injured persons
who choose to receive care and
for whom that care is appropriate
will obtain care that maximizes
the likelihood of desired outcomes
for individuals and society,
is consistent with emerging knowledge,
and occurs in a humane and respectful manner.

SCCM supports collaboration
between all members of the healthcare team.
However, we will realize this vision
only when qualified critical care practitioners
possess the authority to direct the critical care
that patients receive and
accept responsibility for the outcome of that care.
Qualified critical care practitioners possess
similar responsibility for the management of the environment
in which that critical care occurs.

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