

Unhealthiest Reality of Obamacare: Lack of Doctor Choice



By Jamie Wells, M.D. — February 8, 2017



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Obamacare was always about health coverage, not health care. Whatever destiny awaits its future iteration —albeit repeal, replace, repair, what have you, *Trumpcoverage* would be a better suited name than *Trumpcare*.

If the highest quality of medical care persists in being of unequal consideration to access where continuity of care is permitted to fragment further and individual choice of physician be ever limited, then we all lose no matter the new enactments.

Whatever your political affiliation, all we hear about from both sides of the aisle are the two aspects of *Obamacare* that we all desire to keep: not penalizing those with pre-existing conditions and covering young adults under their parents plans until age 26. Bravo to those who successfully distracted the masses from the other significant implications of the bill with these two talking points.

Depending on your political leaning, you either believe these to be originally a Republican notion in earlier legislation or an Obama legacy. Regardless, on these specific components of the law, it seems most people agree. Wow, that's really something these days.

So, can we now move beyond the politicized arena to the other 10,000 or more pages—depending on how you count the massive regulations? Can we just get past the politics and appreciate that there is so much more to the story? That it is a complex labyrinth warranting multi-disciplinary approaches to yield successful solutions that are not one-size-fits-all—ones that involve not only the hospital lobby, but also physicians at the community level, for example, and a [comprehensive understanding of regional disparities](#) [2].

Inroads will only be made when proposals are nuanced for primary care or cardiothoracic surgery respectively, for instance. What is effective in a surgical subspecialty is not necessarily a go in general practice. And so forth...

With access—and convenience—the priority, the highest quality care for all has suffered. This standard should always be at the forefront of policy. Not merely because of a sense of moral duty, but also because there is evidence to support the current approach impedes superior outcomes and incurs unnecessary costs (widely ranging from monetary to emotional and physical ones) when it is not—at the very least—of equivalent importance.

Unintended consequences of expanded access to primary care include diminished continuity of care which is recently tied to greater hospital admissions thereby increasing secondary costs. (1) [A new study just published in BMJ](#) [3] reported this by evaluating 230,472 patients from over 200 general practices in England between 62 and 82 years of age over a nearly two year span to determine if consistent care by a general practitioner influenced hospitalization rates—in particular for conditions deemed manageable in the primary care setting (e.g. long term conditions like asthma, acute issues like gangrene, vaccine preventable like pneumonia and influenza).

The [researchers write](#) [3] “continuity of care is a complex, multifaceted concept reflecting at least four domains: the subjective experience of a caring relationship (interpersonal continuity), a history of interacting with the same healthcare professional across a series of discrete episodes (longitudinal continuity), the availability of clinical and psychosocial information across encounters and professionals (informational continuity), and the effective collaboration of teams across care boundaries to provide seamless care (management continuity).” (2)

Those who achieved greater continuity of care, experienced fewer hospitalizations: “compared with patients with low continuity of care, patients with medium continuity of care experienced 8.96% fewer of these admissions, and those with high continuity of care experienced 12.49% fewer.” (3)

Though this work emphasized the longitudinal variety, the other arenas are also vital to minimizing medical error. Optimizing continuity of care lessens the ever-imperfect whisper-down-the-lane means of communication—a universally present mode as more and more cogs have been added to the caregiving wheel.

Electronic medical records (aka glorified billing platforms) do not pick up the slack, instead they distract and cannot duplicate meaningful discussion. No technology is a sufficient substitute for a conversation between a patient and provider that triggers retention and subsequent memory. Such trust and mutual exchange typically occurs over time. It's why most primary care doctors chose this field—to follow patients over the long haul, not a computer screen.

With continued loss of autonomy to practice medicine, mounting data entry and endless regulations, do you even need to ask 'why?' by the droves more physicians are retiring earlier, desiring to or shifting careers? (4) They went to medical school to be doctors and the ability to be an actual doctor is evaporating. [It isn't burnout](#) [4]. It is system failure when patient volumes escalate and time allotted for ideal care dwindles exponentially.

With reimbursement on the decline, increasing overhead and expanded coverage, primary care has become a high volume proposition which neither benefits the patient, nor the provider. As a result, the trend is shifting to larger practice groups with even larger patient lists. (3) Seeing the same physician has become a diminishing reality as a surge of the use of “mid-level providers” (aka nurse practitioners (NP), physician assistants (PA)) is ever present especially in hospital-owned services. NPs and PAs are invaluable when tasked appropriately, but are routinely compelled to practice beyond the scope of their training—this is not in the population's best interest.

When a staff member is not properly trained for the appropriate patient, it is often a penny wise dollar foolish endeavor. This is repeatedly played out in many health policies. For example, depending on your geography, urgent care centers are saturating the landscape. Most do not routinely staff pediatricians, nor do many emergency rooms these days or for at least a substantial enough number of shifts in the schedule. As a result, those with some level of “pediatric” training (and varying degrees of comfort treating kids) provide care.

The vast majority of ear infections in children are viral, meaning they do not require an antibiotic. Because the clinical acumen is not there due to less training, antibiotics in kids can get over-prescribed. The improper and unnecessary prescribing becomes a contributing factor to the development of antibiotic resistance. A significant issue for the population at large. When a child has 4-5 ear infections requiring antibiotics in a roughly six month period, they are evaluated for potential surgery to place tubes in their ear drums. An invasive procedure exposing them to anesthesia. These types of scenarios are frequent when myopic solutions rule the day. Had the child predominately seen the same pediatrician, this measure alone could preclude navigating unnecessary roads of risk, discomfort and hefty price tags.

These short-term cost cuts also prompt grave consequences. The skeleton crew or poorly trained staffing decisions have tangible results with respect to survival. As I outlined extensively in [To Survive The Hospital, Make Sure Your Heart Stops On A Weekday](#) [5], patients do worse on a night or weekend when admitted to the hospital or when they had a cardiac arrest.

How much more data do we need to review until we recognize that the highest quality of care could be the greatest cost and life saving metric? As it stands, the doctor-patient relationship is eroding when preserving it would be in our best interest.

In medicine, when things are done the right way the first time, then a cascade of negative events is avoided often saving money, sparing unnecessary suffering and providing optimal care— the goal of those pursuing the profession.

Health Policy that will promote long-term gains of a more satisfied workforce, cost-effective care delivery, and more optimal experience for all parties with less opportunity for medical errors should be focused on at the same priority level as speed and uniform access, if not higher:

- Reduction of patient volumes per physician will improve job satisfaction thereby promoting career longevity. Essential given an ever increasing doctor shortage and burnout rates. Patients will benefit as medical errors will likely abate as a result.
- Continuity of care and appropriate staffing especially in hospital environments improves outcomes.
- Emphasis exclusively on access to primary care (e.g. increasing hours or remote care) has “achieved mixed impacts on patient outcomes and some may have had unintended effects on the continuity of the care provided.” (5)
- Measures to free up physician time from unnecessary paperwork and imposition of data entry in electronic medical records will improve patient outcomes, often reduce referrals and excessive testing, thereby amounting to further cost reduction and better care.
- As I always say, “in medicine, good information saves lives. Bad information ends them.” The ability to acquire it must remain a top priority.

NOTES:

Until the pendulum shifts to prioritize continuity of care, refer to [10 Ways to Save Your Life or the Life of a Loved One](#) [6] to be your own advocate.

SOURCES:

(1) (2) (3) (5) Barker, I et al. [Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data](#) [3]. *BMJ* 2017;356:j84.

(4) The [Physicians Foundation Survey Results of 20,000 Physicians](#) [7] ranging from questions about morale, to EMR impact to plans for accelerated retirement.

Tammes P, Salisbury C. [Continuity of primary care matters and should be protected](#) [8]. *BMJ* 2017;356:j373

Loder, E. [Familiarity breeds better outcomes](#) [9]. *BMJ* 2017;356:j558.

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[2] <http://www.acsh.org/news/2016/12/14/top-cause-death-geography-10593>

[3] <http://www.bmj.com/content/356/bmj.j84>

[4] <http://acsh.org/news/2016/09/15/government-torture-physicians%C2%A0where's-outrage-10163>

[5] <http://acsh.org/news/2016/11/07/survive-hospital-make-sure-your-heart-stops-weekday-10406>

[6] http://www.huffingtonpost.com/jamie-leigh-wells-md-faap/10-ways-to-save-your-life_b_9824018.html

[7]

http://www.physiciansfoundation.org/uploads/default/2014_Physicians_Foundation_Biennial_Physician_Survey_Report

[8] <http://www.bmj.com/content/356/bmj.j373>

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