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In healthcare, we're settling for too little

By Robert Pearl, M.D. | June 7, 2017

Ask many Americans about the state of healthcare, and they'll tell you that the care we provide in the United States is the best in the world, if also too expensive. Data tell a different story.

We are in the lowest half of the 20 most industrialized nations in almost every globally accepted measure of healthcare quality outcomes, and at or near the bottom on life expectancy and childhood mortality. Hundreds of thousands of people die annually due to failures in prevention and medical errors. A girl born in Seoul, Korea today has an average life expectancy of 90 years. The same girl in our nation? Seven fewer years.

We accept so much less from our healthcare than we do from our banking, travel, or retail industries. We demand online access to our bank accounts, but we have to call or drive to the doctor's office to get our laboratory results or pick up a child's health form.

We would never fly an airline that didn't offer online booking 24 hours a day, but we wait on hold to talk with a receptionist when we need to make an appointment with a physician. We Skype with friends in Europe, but we miss work to go to a doctor's office for a problem that could be addressed with a digital photograph or video.

How can we break out of this complacency? By understanding how context impacts our perception of healthcare, and taking actionable steps that drive health systems to improve.

Context, perception, and behavior

To understand why patients and physicians so often settle for lower quality care, I wrote "Mistreated: Why We Think We're Getting Good Health Care and Why We're Usually Wrong." The book's central theme is that context shifts perception in powerfully subconscious ways — and, as a result, changes behavior.

To understand this concept, recall the famous Stanford Prison Experiment. In the 1970s, psychology professor Philip Zimbardo took a group of psychologically well-adjusted student volunteers and randomly assigned them to be wardens (wearing aviator glasses) or prisoners (dressed in surgical-type garb marked with numbers). Within 48 hours, the guards saw the prisoners as dangerous and inflicted debasing punishments. The prisoners saw the guards as sadistic and boarded up their doors.

Both groups began the experiment believing the other students were like them. Context shifted their behavior.

The cognitive process behind this shift is often unconscious. More recently, researchers at Stanford put volunteers in a brain scanner and offered them two glasses of wine. The subjects could see a $50 label on one bottle and a $5 label on the other. What they didn't know was that the two wines were identical.

When asked which they preferred, their overwhelming preference was for the expensive bottle, which you might assume. But it was much more than that. In fact, their brain scans showed that the reward center of the brain actually activated far more strongly when they sipped what they believed to be the higher-priced libation, even though the taste and aroma were identical. There's a parallel to healthcare here: Context shapes our perception of good care.

"Mistreated" offers a road map for the future. It's drawn from my experience as a physician leader at The Permanente Medical Group and the Mid-Atlantic Permanente Medical Group. And it posits that when patients are empowered and engaged — and physicians are primed to consider their experience outside the office setting — they can drive healthcare forward together.

The program is built on four pillars, each of which improves operational outcomes. Understanding these pillars, and seeking care that includes them, is critical to becoming better patients and physicians.

Accepting integration

The current American healthcare system is still fragmented, with doctors in small offices and hospitals in each town. Patients can press for greater integration by seeking treatment from multi-specialty medical groups, where doctors are seen as colleagues, not competitors. When collaboration and cooperation increase, both within and across specialties, quality of care is destined to improve.

Embracing capitation

When physicians are prepaid to care for a population of patients, they invariably offer more preventive care, avoid medical error, and provide better chronic disease management. Diet, exercise, and preventive screening can have a powerful impact on a disease like diabetes, which affects 30 million individuals.

At Kaiser Permanente in Northern California, capitated payments — and the holistic, coordinated care they drive — enabled us to control hypertension 90 percent of the time and screen colon cancer in 90 percent of age-appropriate individuals. (By comparison, nationwide rates are 55 percent and 50 percent, respectively.) Out of 1,000 programs in the U.S., ours was the only one to be rated with five stars by the National Committee for Quality Assurance for both commercial and Medicare patients.

Using existing technology

The neurobiology I describe above explains our attraction to new technology that glitters, rather than older methods that are tried and true. In healthcare today, we are excited by expensive new technology, from artificial intelligence to genomics. We're often missing what is already available and often relatively inexpensive.

And it turns out that existing technology such as video, a comprehensive electronic health record, and data analytics — paired with behavior change — offers the most promise to improve healthcare. Patients fail to recognize the power of comprehensive electronic health records that contain all of a patient's information across physicians. These records make it much harder to ignore gaps in preventive care, identify potential medication incompatibilities, and minimize complications from chronic disease.

Payment matters here, as well. When doctors have no incentive to respond to email or offer video visits, they perceive these tools as risky, even if they are more convenient for patients — and even though they enable patients to take better care of themselves, leading to improved outcomes.

Nurture physician leadership

The ingredient that unites these pieces is physician leadership. Doctors are often resistant to hospital administrators or insurance executives, but they will be open to change when the process is led by physicians they know and trust. Brain scanning studies have shown how fiercely the fear center of our brains reacts when people feel manipulated.

Effective leaders bring doctors together and overcome their unwillingness to surrender some of their autonomy for the greater good of patient care. They make the adjustments needed in compensation to better reward prevention. They find ways to offer patients choices, including through 21st century mobile technology.

We need to train more doctors in business and leadership skills. When we build a new surgicenter, we view the return on investment over a decade or more. The same should be true for investments in physician development.

The future

Our nation is facing a healthcare crisis. We already spend 50 percent more than any other country on healthcare, and our results are mediocre at best. In "Mistreated," I point out that the blame should not be placed on poorly trained doctors or uncaring hospital executives, but on the system itself.

By understanding what's possible today, we can modify the context of the American healthcare system — and how it is structured, reimbursed, and technologically supported.

When we do, hundreds of thousands of lives will be saved.

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