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Changing medical relationships after the ACA: Transforming perspectives for population health



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ABSTRACT

American health care has undergone significant organizational change in recent decades. But what is the state of core medical relationships in the wake of these changes? Throughout ACA-era health care reform, the doctor–patient relationship was targeted as a particularly important focus for improving communication and health outcomes. Recent developments however have shifted the focus from individual-level outcomes to the wellbeing of populations. This, we argue, requires a fundamental rethinking of health care reform as an opportunity to renegotiate relationships. For example, the move to population medicine requires that the very concept of a patient be resituated and the scope of relevant relationships expanded. Medical relationships in this era of health care are likely to include partnerships between various types of clinicians and the communities in which patients reside, as well as a host of new actors, from social workers and navigators to scribes and community health workers. To address the upstream determinants of population health, providers must be increasingly willing and trained to collaborate with community stakeholders to address both medical and non-medical issues. These community-based partnerships are critical to providing health care that is both relevant and appropriate for addressing problems, and sustainable. Approaching health care reform, and the focus on population health, as a fundamental reworking of relationships provides scholars with a sharper theoretical lens for understanding 21st century American health care.

Introduction

As a response to ongoing initiatives to improve American health outcomes, reduce costs, and address health disparities, many scholars have analyzed the relationships that develop in medicine – particularly between practitioners and patients. As the most recent wave of health care reform has taken its course, marked most importantly by the passage of the Affordable Care Act (ACA) in 2010, these discussions have often centered on the fate of the traditional doctor–patient relationship. These critiques have arisen in response to what is widely assumed to be the besieged nature of this particular relationship (Senger, 2013; Fallowfield, Guarneri, Akif Ozturk, May, & Jenkins, 2014; Singer, 2014).

More recently, this scholarly focus on the relationship between practitioners and patients has expanded to include the emerging actors of an increasingly interprofessional medical workforce, such as nurse practitioners, physician assistants, behavioral health specialists, and scribes. From the perspective of medical relationships, this expanded approach to medicine has required a range of strategic considerations

not only to develop optimal ways for collaboration, but to overcome competitive and territorial professional dispositions (Baker, Egan-Lee, Martimianakis, & Reeves, 2011; Gittel, Godfrey, & Thistlewaite, 2013). Yet, even this expanded scholarly focus barely captures changes afoot in medical relationships in an era increasingly focused on populations and the social determinants of health, particularly in the wake of the ACA (Starr, 2013; Stoto, 2013). Beyond the clinical actors who are central to the establishment of new forms of interprofessional and team-based medical care lay a fundamentally different cast of key characters, from social workers and navigators to community health workers, and hospital-school liaisons to name a few. Many scholars have noted the increased importance of those actors that we broadly define as practitioners (Browne, Darnell, Savage, & Brown, 2015; Cosgrove et al., 2014; Rosenthal et al., 2010). In this paper, however, we use the word “practitioner” in a way that captures our argument about new medical relationships, beyond the traditional sense in which the word has been used as synonymous with “clinician.” This expanded view of who constitutes a medical “practitioner” is central to a new way of thinking about medical relationships them-

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selves.

Accordingly, we argue that a theoretical shift is necessary. Specifically, we underscore the importance of framing health care reform as an opening for a fundamental reworking of medical relationships that transcend the traditional scope of medicine, beginning with the ability of various non-medical components of communities to bring about change on the local level. Specifically, we suggest that understanding contemporary health care as concerned with cultivating these new relationships is a critical step for addressing health on the population level.

New and changing medical relationships

As we have noted, most discussions about medical relationships have focused on the important relationship between doctors and patients. In the past, these discussions tended to center on modes of communication. In the 1950s, for example, *Szasz and Hollender (1956)* discussed the potential for the emergence of new models of doctor–patient communication that could be effective depending on the type of illness and model of care. An acute illness such as an infection or injury could be treated primarily, if somewhat mechanically, with medical expertise and limited input from patients. Here, the biomedical model, driven by standardized assessments and best-practice guidelines, emphasizes a fixed logic or structure of patient care that limited the amount of patient involvement in the medical relationship.

Chronic illnesses, however, require the cultivation of new relationships that transcend those of the biomedical model. Chronic medical care is often dynamic and long-term (*Wagner et al., 2001*). Patients, therefore, must be consulted and work collaboratively with providers to establish a plan of care that is both rooted in evidence as well as in line with patient preference, that is, guided by the goals patients set for themselves. Developed out of a chronic illness model, the tradition of patient-centered care thereby creates opportunities for patient-provider collaborations, fortified by a strong commitment to open and bidirectional communication (*Berwick, 2009; Pelzang, 2010*).

Some scholars have argued that the traditional biomedical model is insufficient for the treatment of chronic illness, especially because it does not foster the kind of relationships that are required to both prevent and manage these conditions (*Longino & Murphy, 1995; Mirzaei et al., 2013*). Discussions recently have focused on alternative approaches that rely on care coordination among providers and settings, such as primary and specialty practices, ambulatory care, and long-term facilities (*Burns & Pauly, 2002*). The proliferation of particular roles within health care systems is not only a matter of complexity; these roles produce qualitatively different modes of interaction formalized in new relationships.

In many ways, however, the focus on chronic illness merely expanded – instead of rethought – the biomedical model. For example, including patients in each phase of treatment does not guarantee that their input will be taken seriously, just as open communication does not necessarily change power dynamics. Ultimately, the treatment of chronic illness focuses on treating individual patients after the onset of illness and according to a traditional medical model (*Halfon et al., 2014*). Although the prevention of chronic disease has become popular through practices such as health promotion and expanding access to primary care, these practices often assume a biomedical paradigm that emphasizes individual-level behavior and outcomes rather than population-level concepts, such as community well-being. For this reason, the move to population health in medicine increasingly requires a substantive adjustment in relationships as well as systems that are responsive to and reflect these new relationships.

Pre-ACA policy developments

Although the ACA facilitates the formation of new relationships for purposes of promoting population health, several aspects of the law

have the potential, as well, to facilitate a rethinking of how doctors, patients, and communities interact in relation to these structural changes. Before turning to the ACA in detail, however, it is important to note that the current wave of health care reform was preceded by several important policy developments. During the 1960s. There is a space here that should be deleted.s, for example, as part of President Johnson's "War on Poverty," community health centers were envisioned as a viable modality of treatment. The Economic Opportunity Act of 1964 provided the initial impetus for this strategy (*Lefkowitz, 2007*). Later legislation consolidated and focused these programs (*Bailey & Duquette, 2014*). Local resources were combined with Federal dollars to combat poverty by providing primary health services to underserved areas. Neighborhood clinics were thus established in low income urban and rural communities (*Geiger, 2005*). The general idea was that these centers would have impact on multiple levels. For example, jobs would be created, along with training local persons, while the health of poor communities was improved (*Geiger, 2003*). Moreover, the services offered would be low-cost and sustainable, due to local involvement in planning and implementing these interventions. Key to this approach is that health should be viewed holistically. Familial, environmental, and employment factors, for example, were introduced as important determinants of health. Additionally, patients should participate actively in their treatment. Community health centers, in this sense, should be governed by local boards that include patients. As a result of these changes, services would be culturally appropriate and situationally relevant, thereby improving community life. Prevention and education, likewise, would be elevated in importance. This shift in orientation can be viewed as part of the social movements that emerged during the 1960s. The hope was that average persons would participate more fully in vital institutions, including health care, and as a result would agitate for further equity (*Geiger, 1993*). Although funding waned for health care operating on the community level in the 1980s, the fundamental goal was that social and health disparities would be reduced, as institutions become more democratic.

Common to both the community health center movement and the ACA is an emphasis on activating communities to prevent illness and promote wellbeing. Population medicine, as a result, is thought to intervene before the onset of preventable diseases in order to address fundamental causes (*Phelan, Link, & Tehranifar, 2010*).

Changing medical relationships under the ACA

The ACA introduced various incentives for moving to this population-based approach, financial and otherwise, providing significant opportunities for health care practitioners to engage community perspectives in this new era of medicine. One reason why relationships are changing is that patients themselves are being redefined within the context of population medicine. This is true for several reasons.

One major cause of the impact patients are having (and will continue to have) on these transformations stems from the fact that the ACA has dramatically increased the number of access points to the American health system, especially through expanded Medicaid eligibility for those states that have opted to accept federal funds, and through the establishment of a new health care marketplace for those who are not eligible for Medicaid and lack access to employer sponsored health care (*Rosenbaum, 2011; Obama, 2016*). Even as expanded access through the ACA has solved one critical problem, it has put pressure on existing relations – especially doctor–patient relations – by raising questions about the capacity for existing practices to meet the needs of the some-odd 13 million Americans who now have health insurance who previously did not (*Hall & Lord, 2014; Kaiser Family Foundation, 2016*). This decrease in uninsured ranks, and attendant influx of new patients, is also putting pressure on the various moving parts of the American health care system to innovate, particularly through the introduction of team based care and new

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