

# Thinking Out Loud... A Renewed Commitment

*“We need to be more concerned about the patient. That’s where the power should reside.”*

—Linda Aiken, Director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing

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While reading the above quote, my mind rushed back to 1994 when, as an HII Project Leader in a dialysis facility, I encountered a group of dialysis patients, admittedly by chance, who were taking their own vitals and preparing themselves for their dialysis treatment. They were intent on their tasks and seemed relaxed, if not content. There were just four of them. In a few minutes, they noticed me standing about six feet from their chairs and they smiled, saying not a word as they continued their work. I smiled in return.

It impressed me that these patients were in control of their own care—at least to the extent that their knowledge allowed them. It also impressed me that they seemed healthier than the other patients who were being treated at this facility.

Curious about this unusual scenario, I queried a physician after one of our in-service sessions about what I had just seen. We discussed his facility’s self-care program, especially the method that the facility used to select patients for this program. My question was direct: “Do you choose patients for this program because they are healthier than your

other patients?” The response to this question was, “No.”

The facility targeted patients who they believed were tractable—that is, who had the will to learn what they needed to do, who had the patience to learn how to do what needed to be done, and who were able to demonstrate that they understood when to do what they had learned. Only over time did the benefits of the patient self-care program emerge, the same ones I had just seen for myself.

Fast-forward to January 4, 2005, when the article, “Patient Self-Management of Anticoagulation: An Idea Whose Time Has Come,” appeared in the *Annals of Internal Medicine*. This article affirmed my 1994 experience. What is remarkable about this study, however, is its finding that patient self-management outcomes matched those of a specialized anticoagulation clinic and, therefore, the study concluded, this model of care is worthy to be considered as a long-term model of care for the management of anticoagulation. This is a patient-centric model based on a similar level of commitment required of a self-care dialysis patient.

If the patient self-care model is effective and efficacious across specialties, then connecting patients with their caregivers at the point of self-care, wherever it occurs, is wise and can be beneficial to everyone involved. Having said this, if the model of patient self-care is valid, then the relationship between the patient and the caregiver will necessarily evolve into a different kind of relationship.

### **A Renewed Commitment**

Were we to ask a caregiver, “Why do you take care of patients?” what would the response be? Would that caregiver say, “Because that’s where the power is”? Most likely not. If asked about the essence of the patient-caregiver relationship in a self-care model, what would the answer be?

This is a profound question, because the patient-caregiver relationship is based on an implied covenant between the two.

Though an ancient concept, a covenant is a modern operating principle within this context. In its simplest terms, a covenant is a commitment. The covenant between a caregiver and a patient, however, is not a

simple reality. It is complex. It is at once a dependent covenant in which the performance of one person's prior action determines the performance of another person's action, as well as a concurrent covenant whereby the one person can only perform an action when another per-

### **Interoperable Technology Links Patients and Caregivers**


Let's fast-forward again, this time to April 27, 2004, when President Bush mandated that the U.S. adopt interoperable electronic health records (EHRs) by 2014. Interoperable EHRs are records that can effec-

more preferable thrust than a focus on disease—as well as to help them manage their healthcare decisions. This goal, when achieved, will, I believe, evolve the patient-caregiver covenant and extend it to new and deeper dimensions, as described above, so that, ultimately, a new kind of healthcare system will emerge.

Interestingly, the first two goals of Dr. Brailer's report—to "Inform Clinical Practice" and "Interconnect Clinicians"—are the original foundations of the HII TIME System®, and collectively the four goals substantiate the logic of the statement we first made in this journal in 1999; namely, that *The practice of medicine is the practice of information.*

At the time, virtually no one appreciated our logic and only a few agreed with it. Today, under the aegis of the federal government, the healthcare industry is moving inexorably towards the amalgamation of medicine and information technology. Ultimately, their integration will have the power to transform our concern for the patient and the patient's own concern into the highest quality of patient care ever experienced by our healthcare system, the enabling link of the patient-caregiver partnership. Therein lies the power.

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son performs an action at the same time. It also is an independent covenant—that is, the performance of an action will happen whether or not the other person does anything—as well as a covenant of grant in which the one person gives something without any obligation of the other party to do anything in return.<sup>2</sup>

My approach to the patient-caregiver covenant in a self-care model is similar to the one articulated by Leland Kaiser, the renowned healthcare futurist. He states: “To make the covenant relationship work [in the new millennium healthcare system], everyone is required to make significant changes. Not only providers must change, patients must assume responsibility for their own health behaviors. Patients are as important a part of the healing covenant as the physicians who treat them.”<sup>3</sup>

tively talk to each other and also share data among different kinds of healthcare information systems without using expensive interface technology. As part of this mandate, he required a report from the newly appointed National Coordinator for Health Information Technology (HIT), Dr. David Brailer, within 90 days of his appointment. The purpose of the report was to describe a strategic plan for implementing HIT nationwide across the board in both the public and private sectors.

The resulting report<sup>4</sup> had only four goals, and one of them centers on the importance of the consumer's role (that is, the patient's role) in his or her own healthcare. This goal, the third goal, is to “Personalize Care” so that consumers can oversee their own wellness—a

### **References**

1. Romano M. Information Power. *Modern Healthcare* August 23, 2004, p 49.
2. Crooks GM. *Creating Covenants, Healing Health Care in the New Millennium*. Old Lyme, CT: Medical Vision Press, 2000, pp 25-27.
3. *ibid.* p xii.
4. Office of the National Coordinator for Health Information Technology (ONCHIT) Executive Summary in response to Executive Order 13335. **D&T**