leadership page

the seven deadly sins of health care

part i

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a few years ago, harvey fineberg, md, phd, then president of the institute of medicine, developed his own set of 7 deadly sins for public health (1). of the original 7 sins, he kept sloth, greed, and gluttony, but he added ignorance, complacency, timidity, and obstinacy to round out his public health mix. his sins and corresponding definitions tended to focus primarily on the broader public—for example, he noted that sloth blocks people from doing daily activities that would keep them healthy and gluttony keeps people eating when they are no longer hungry. however, i suspect his choice of “sins” could also apply to health care providers, companies in the health care market, policymakers, and other public health stakeholders.

in this first of a 2-part leadership page series on these 7 deadly sins, i want to focus on greed, complacency, timidity, and obstinacy: the challenges they pose to public health and what is being done to overcome them.

greed by definition is “a selfish desire to have more of something” (2). for a very small minority of physicians, greed can lead to excessive testing and procedures to increase their bottom line. with public distribution of annual medicare billing and payment records and whistleblower suits, much attention has been brought to these physicians. similarly, some institutions have been “called out” for excessive payments to high-level management or have been accused of treating insured patients differently from those who are uninsured or on medicare or medicaid. the pharmaceutical, health insurance, and device industries are also not immune from greed, whether it is disproportionate chief executive officer salaries, high costs of drugs—particularly generic drugs recently—or the rush to get drugs or devices to market on the basis of research derived from data that is subsequently identified as flawed.

although greed does not characterize the majority in any of these situations, everyone is affected when cases of greed become the focus of the media, policymakers, and/or the public. there are many examples of the “sins of a few” resulting in “shackling of the masses,” with both ethics and quality of care of physicians, for example, being often questioned and never assumed. on a broad scale, some of this culture of suspicion has led to the ongoing evolution from a volume-focused to a value-focused health care system. this transformation will make it more difficult for providers and institutions to financially benefit from unwarranted tests and procedures. additionally, with a significant number of americans receiving health insurance as a result of the affordable care act, it is more difficult for hospitals to “cherry-pick” patients on the basis of insurance status, but this still can and does occur. an increased focus on outcomes and penalties for hospital readmissions also means that hospitals are incentivized to make sure that all patients receive the most appropriate care and are even provided post-discharge outpatient services to help ensure a successful transition from hospital to home.

over the last decade, the american college of cardiology (acc) has worked hard to protect its members and the patients they serve from the effects of greed. over the last decade, the college has led the way in the development of appropriate use criteria (auc) to help prevent unnecessary tests and procedures and to help clinicians select the right patient for the right diagnostic test at the right time. the auc also provide a practical standard on which to assess
and understand variability. Use of AUC will become even more important next year as a result of the Protecting Access to Medicare Act of 2014. Starting in January 2017, clinicians will need to consult with AUC through a clinical decision support mechanism for all Medicare patients receiving advanced imaging (cardiac nuclear, computed tomography, and magnetic resonance). The College is actively engaged with members of Congress, the Centers for Medicare & Medicaid Services, payers, and other health care societies to provide a hopefully seamless implementation of this mandate.

The ACC is also on the cutting edge of quality improvement services for hospitals and institutions that are intended to help facilitate cultural changes and move away from simply focusing on financial gain. From its growing suite of NCDR (National Cardiovascular Data Registry) hospital and outpatient registries to initiatives like Surviving MI and Patient Navigator, the College is committed to helping institutions realize the benefits—which can also be financial—of high-quality, evidence-based, cost-effective care. The ACC is also working closely with payers, the Centers for Medicare & Medicaid Services, and pharmaceutical and device companies on new drugs, devices, and therapies by using registries to help track patient outcomes and facilitate development of clinical guidance, bringing together diverse stakeholders for roundtable discussions around new and emerging treatments, and/or developing educational programs and tools to help clinicians determine the best course of treatment on the basis of the latest science.

There is still work to be done to further minimize the effects of greed. For example, pharmaceutical companies should not be allowed to charge more for drugs in the United States than they do in other countries. The United States and New Zealand are the only remaining developed countries without some system of drug price controls. Some also question the often 20-year window before drugs can become generic. On the payer front, we continue to hear on a too-frequent basis about patients being denied appropriate treatments as a result of pre-authorization requirements, radiology benefit managers, or arbitrary internal policies.

Complacency and timidity also pose significant threats to public health. Complacency, according to Fineberg, is the acceptance of things as “normal” that are actually “preventable or avoidable,” whereas timidity prevents “individuals from demanding health-enhancing changes to policy and practice” (1). It is easy to become complacent, especially given the ever-increasing demands on our time both personally and professionally. Continuing to do something the way it has always been done, especially if it works, is often easier. Over the years, complacency has limited the roles of care team members; minimized the focus on prevention efforts; and affected the use of new drugs, such as novel anticoagulants.

Like greed, changes in the health care environment are forcing us out of our complacency as well as our timidity. Workforce shortages are opening up new doors and opportunities for the entire cardiovascular care team. Increasing integration with hospitals is also requiring professionals across the care continuum to work together in new ways—and not be timid about doing so. The increasing focus on curbing health care costs and improving patient outcomes also means an increased focus on prevention activities. Encouraging healthy life-style choices and educating patients about risk factors like smoking, high cholesterol, hypertension, and diabetes are taking on new importance and bringing together seemingly unlikely partners in the form of industry, consumer companies, health care organizations, and government agencies. Additionally, new technologies are making it easier to share research results or put decision-support tools in the hands of clinicians at the point of care, thus making it easier for new drugs and treatments to be adopted.

On the cardiovascular front, the ACC and its many partners have worked to develop, refine, and update state-of-the-art scientific reviews, consensus statements, and clinical guidelines to synthesize and solubilize best practices and help define where data are lacking to stimulate research. The ACC is also constantly working to ensure that the professional needs of the entire cardiovascular care team are met, whether it is through educational programs, leadership development opportunities, or advocating for policies at the state and national levels. Prevention and the health of populations are also at the heart of the College’s strategic plan, ensuring that we will not be complacent in this area. Programs like CardioSmart continue to provide patients with important information about healthy life-style choices, and partnerships like the Diabetes Collaborative Registry, Million Hearts, and the NCD Alliance are bringing together diverse stakeholders to tackle heart disease and related risks around the world. When it comes to new drugs and treatments, the College has a growing suite of mobile applications, quality toolkits, digital tools, and clinical data registries to encourage clinician adherence to guideline-recommended care. The ACC also makes it easy to overcome timidity with its robust member sections and council, more than 80 chapters around the world, and a comprehensive
advocacy department. All of these resources offer a place for members to raise issues, share best practices, develop solutions, and lead actions.

Fineberg defines obstinacy as the refusal to accept evidence on best practices or to change practices or customs that are familiar (1). Somewhat like complacency and timidity, this “sin” requires movement beyond one’s comfort zone. We see obstinacy, or in some ways denial, a lot in health care. Examples include refusal to acknowledge new clinical guidelines that differ drastically from what had become “the norm”; slow adoption of health information technology; limited participation in quality improvement programs; and failure to leverage skills of care team members, primary care, or other specialties. I would also argue that lawmakers’ failure to address malpractice reform on a national level as of yet is another example of obstinacy in health care.

Incentive payments for participation in programs like the Physician Quality Reporting System and the Electronic Health Record Incentive Program are helping some overcome their obstinacy. Successful examples of hospitals and practices utilizing the full scope of care team members to improve patient outcomes and reduce readmissions also serve as catalysts for change. In cardiology, recent studies on the basis of data from the ACC’s registries are helping to prove that adherence to new guidelines improves care and saves lives. Of course, there is still work to be done, including finding ways to reach lawmakers about the importance and importance of malpractice reform. As implementation of the Affordable Care Act and the more recent Medicare and CHIP Reauthorization Act of 2015 continues, finding ways to help clinicians overcome obstinacy and see the value in new best practices or processes will be critical.

The ACC recently overcame its own battle with several of these “sins,” especially complacency and obstinacy, by transforming its governance structure and processes. It is not easy to change practices and customs that are familiar, but the ACC’s leadership recognized the value and importance in creating a system that was more nimble, strategic, accountable, and representative of its growing membership. Some key highlights include:

- The board reduced in size from 31 to 11 members. (Board size will be 19 in 2016, with 12 positions being retired. Further reductions will occur in 2017, with an 11-member Board in place by 2018.)
- Board members will serve 3-year terms, renewable for 1 additional term.
- Board officers will be limited to: President, President-Elect, Secretary, and Treasurer.
- Board members cannot hold positions on any other ACC nonstanding Board committee except for the Board of Governors Chair.
- A newly formed Membership Committee will make sure the Board of Trustees is aware of the needs and challenges of all members of the College.

Reaching consensus around these changes was a 2-year process that required everyone involved to put aside greed, complacency, timidity, and obstinacy. The resulting structure and process, although clearly a work in progress, is a testament to each and every Board of Trustee member’s unwavering commitment to the College and its mission. Having witnessed leadership in many organizations, it requires a high level of selflessness and a vision of a better future for the College for many of its leaders to vote themselves out of office, particularly given the successes achieved with the current leadership model.

Because of these changes, the College is in an even better place to help members overcome the 7 deadly sins of public health and ensure that patients are getting the care they deserve.

Note: This is the first in a 2-part series. Next month’s Leadership Page will focus on sloth, ignorance, and gluttony.

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REFERENCES