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The Patient Card and its Position in a 'New Health Care System'

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1 INTRODUCTION

It has become modern to devilish patient cards as the origin of the evil. The reproaches are running from the 'glassy patient' via the 'glassy physician' to the dictatorship of the Health Care System. Mostly topics are under exposition which are not at all related to cards but to medicine itself. But these topics are becoming obvious because the card with its necessity for structuring and standardization makes it visible. For all people acting in Health Care Systems - patients including - is it much easier to decline new media with more or less relevant reasons, instead of taking into account the demands of chronic ill patients, the demands of the modern medical documentation and the demands of the actual medicine.

Also the patient card and the informational self-determination are only parts of a health care system of the future. This system will look very different from the one which we are dealing with today 4.

Figure 1 shows in a very simple but therefore much more clear view a model of the health care system of the future, which most patients and a lot of physicians and other health care workers wishes already now. A view to single nails of this model must lead compulsory to misunderstandings and to contradictions. Also the topic patient card must be investigated under the aspect of the whole model of the health care system of the future. Two main groups of factors effect the patient-oriented health care system - judicious and technical factors (see Fig. 1). The patient card belongs to the technical side, the informational self-determination e.g., one of the most important factors of the health care system of the future, be longs to the judicial factors (in Germany 'Grundgesetz' - Constitution - and Highest Court decisions). Both effect patient decisions not only directly but also indirectly via the Patients Medical Record.

R. Posch (ed.), *Communications and Multimedia Security*

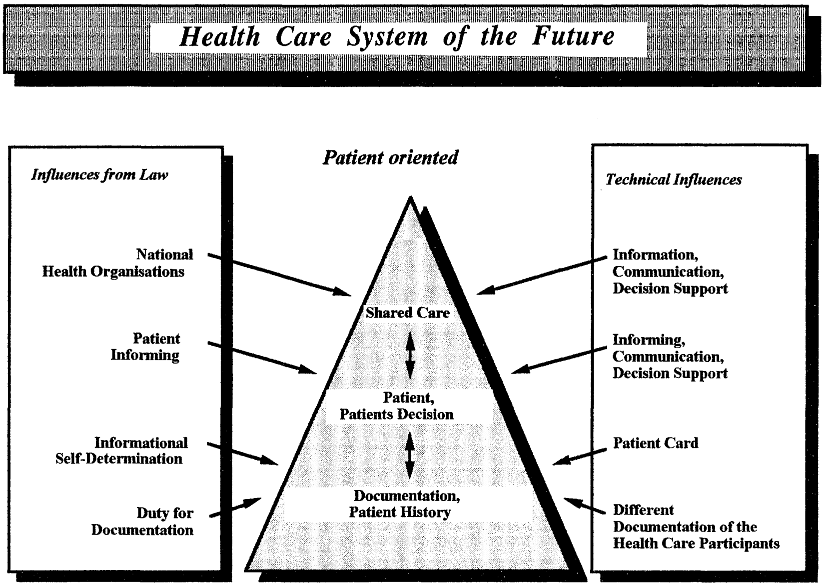

Figure 1 Health Care System of the Future.

The discussion about the position and value of patient cards cannot be held without taking into account the medical documentation in form of a complete Patient Record, which the patient owns, which belongs to him and to which he has all the access rights. The card is only the medium, which contains the Patient Record. German leading legal position is that kind of thinking, if the patient buys the card and health care professionals and health care providers fill the card with the Patient Record, the patient has all the rights to read, to write (his own documentation, e.g. pain diary), to correct and to delete data (Wellbrock, 1995). The cooperation in partnership between patient and physician is the most important supposition for running such a model. For further analysis of the problems of 'Patient Cards' and 'Complete Patient Record' the goals of a health care system of the future, the presuppositions to gain these goals and the results of these goals for the individuals and for the society must be investigated.

2 GOALS OF THE HEALTH CARE SYSTEM OF THE FUTURE

The goals of a health care system of the future for the patients could be postulate easily, they are at least in Germany on the way, in little steps indeed (BMG, 1993), (Vollmer, 1994). These goals are:

1. The patient makes all the decisions, which effect him and his body,
2. for that, the patient is educated, informed, and enlightened (Patient Informing),
3. the patient possess, owns, decrees, and decides about his Patient Record (Informational Self-determination).

For most of the patients, health care professionals, health care providers, social workers etc., these goals seem to be utopian and not realistic, because - it is to hear everywhere - the patient is absolutely not able to understand the things and posed on that to decide respectively. These acts of parrying can be unmasked easily. For thousands of years finally it was too comfortable for health care professionals of any kind, for what one should take more efforts and annoyances, and finally to admit that medicine is not yet far enough developed to answer most of the patients questions. These physicians knowing those and telling it frankly to their patients, and building the basis of a cooperation in partnership are becoming more and more (Stacher, 1991[1]).

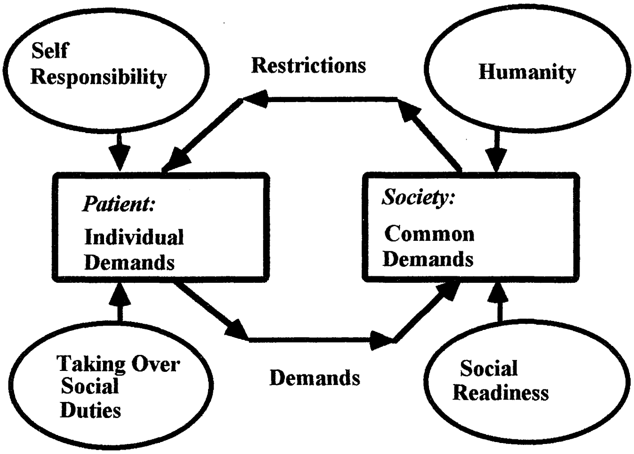

Figure 2 Circle of decision in a health care system of the future.

Figure 2 shows the circle of demands and restrictions and the balance between the individual and the society. Within the ovals are placed the factors and suppositions which effects the balance and the circle. Probable the main supposition is the general acceptance, that humans - that means also patients - are responsible for themselves. Humans, especially patients, must gain the understanding that their actions will have influences on their life - in both directions.

The first of the above mentioned goals is exact no goal but daily reality. Any action of a health care professional to the patient is prosecuted by law, if the patient is not giving his agreement in advance. This agreement is the most important decision which the patient has to do so often, that he does not become aware of that in most cases that he makes a decision at all.

Within the daily procedure working jointly on the patients problems (not: professionals working on the patient - what one can hear widely distributed) it must be investigated the different steps - proposal - understanding - decision - action -. All the persons concerned (exception - the patient) take it as self-evident that the patient agrees anyway, because he does not have the understanding and needs a therapy any kind anyway. Many words are spoken about the 'responsibility' for the patient, what should that mean? Bad decisions and false actions had been taken and are to take also in future by the patient. Everybody has to die alone. Within the last years in Germany the things have become better, many physicians try at least to make the patient the kind, the reaction and the result of a planed treatment understandable, so that the patient might be able to make a 'better' decision.

Of course, social and organizational structures, grown over a long time, cannot be changed from day to day by a law or decree. Until now the patient only has a very small percentage of the knowledge, which he really needs to make 'right' decisions. Today one starts the education, the informing, the conveying of knowledge, only when it is needed urgently. Why not start this education in medicine, on the human body and life, much earlier, in childhood, like the education in teeth brushing.

An example of the importance of that statement is coming from the United States (McDonald, 1994). It could be assumed easily that this figures are not different in Germany or other European states. McDonald has shown that approximately 2/3 of all patients in a waiting room of a doctor's of five would not sit there, if they would have only the slightest knowledge of medicine and of their own body. Same man within this article stated, that 2/3 of the patients which do need the doctor urgently, are looking for the doctor to late, and therefore causes more suffering and more costs as it would have caused if they would have gone to doctor on time. Also here again the supposition of a minimal knowledge about medicine and their body. The shortening of this relation, in a minimal rate only, would already lead to a drastically decrease of costs and in crease of life quality of the population.

The third demand, patients ownership and belonging of the patient record, leads directly back to the 'informational self-determination' and Larry Weed, who asked already in 1976 his colleagues: 'Who is most interested in the patient record?' He answered immediately this question: 'The patient!' And than he made the conclusion: 'Give it to him.' (Weed, 1976) 20 years ago this demand was technically impossible, today we have the media to do it - Smart Card, Hybrid Card.

How could the patient be able to practice fully the informational self-determination, if he does not have all the rights for the object carrying the informations. It is of course open, that the health professionals any kind are keeping their own records and files. The rights for these re cords and files are well defined in the western world. The technical realization for a patient record on a Hybrid Card is not the problem anymore. The needed read/write devices are under development and will be ready within the next months. Concepts for realization for special parts of Shared Care are already existent (Zimpelmann, 1995[1]), (Zimpelmann, 1995[2]).

3 SUPPOSITIONS TO GAIN THE GOALS

As usual in human lives the understanding of the problems of the 'other' and a little bit of good will for cooperation belongs to the suppositions to reach the above described goals. One should not be blue-eyed, it will be a hard work to realize alone these suppositions, but it is al lowed to think and count on the good in every human being. Already Cicero laid the fundaments for this needed kind of thinking humanistic: 'Aber genug davon; es ist offensichtlich, daß es einen anständigen Menschen gar nicht geben kann, wenn nicht Billigkeit, Zuverlässigkeit, Gerechtigkeit von der Natur ausgehen, sondern all dies nur auf den Nutzen bezogen wird.' (Cicero, 1988) p. 123). (Translation: Enough of that, it is obvious, that there cannot exist decent mankind, if equitableness, reliability, righteousness does not come from nature but is related to benefit only.)

Part of these suppositions is surely the acceptation of the position and the tasks of the other. To reach that is not easy, but possible. Within our new society of the 'Second Wave' (A.

Toffler) the mutual acceptation concerning the tasks and the social and economical positions not self-evident. Unfortunately the same is to be seen in health care, though the suppositions are looking better for a non-hierarchical partnership. 'The Third Wave' offers better conditions for the future development (Toffler, 1972). These suppositions are culminating to the demand - *talk to each other!!* When people talk to each other, they cannot act in the same time contrary to the described goals. These statements are not new, but they have to be spoken and written again and again to get a new human society for the best for the patients.

4 MODEL FOR REALIZATION

How could the above described goals and the (to implement in advance) suppositions be reached without to built 'Utopia'? There are again very few modules of a very simple model:

- Changing of thinking of ***all*** persons concerned in health care towards patients problems solution (treatment and caring of ill humans and not of diseases) in a real partnership,
- further development of the 'problem-oriented medical record' (Larry Weed, 1970),
- motivating also the patient to do his documentation,
- creating and implementing the technical supposition (patient owned Hybrid Card).

The first part of this simple model is obviously also the most difficult, though already many physicians - but by now means enough - believe and act on the basis of this philosophy. The medicine which deals with the whole human being has many facets, but indifferent to its image, it starts to become real (Stacher, 1991[2])

Changings in Health Care

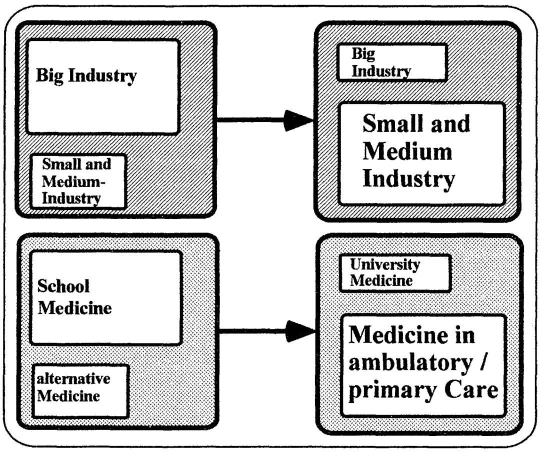

Figure 3 Changings to a future health care system.

The figure 3 shows very clear the potential which is included in the re-structuring of the health care system in the sense of A. Toffler's 'Third Wave' (Köhler, 1995), (Toffler, 1972).

The 'Big Industry' in health care will go back to let more space for decentralized and partly specialized 'Small and Medium Industry'. A large part of the so-called alternative medicine is done today already in primary care - not only by GP's but also by specialists.

The medicine dealing with the whole patient has to go back to Larry Weed and will take his revolutionary concept for medical documentation from the year 1970 and will bring it to life and into practice again - widely distributed (Weed, 1970). Practice means not only the practical medical and documentary work but also the general work in the practice of GPs and specialists. In Germany there exist already a Doctor's Office Computer System which has the problem oriented medical record included. It seems not to be very difficult to develop the system further for the needs of the future documentation system, so that it could be sold as a 'plug-in-module' for any system.

A very important part of the patient record is that part which is done by the patient himself. Already today many patients are making their own documentation - pain protocol, allergy protocol, diabetes protocol etc. Giving to the patient a diskette with a little program on which the patient can do it now on his home computer, would increase on one hand the quality of the documentation and would lead on the other hand to an integrated documentation, integrated into the documentation of the doctor, so that he can make real use of it. Chronic ill patient are mostly very interested in their illness and do know a lot of the diagnoses and treatment. They will perform a very good documentation. The turn into a system which uses the Smart Card or a Hybrid Card is easy. The operating systems of Smart Cards with included routines for security and privacy are ready for medical usage. Also the Hybrid Card (chip on one side and optical memory on the other) for storing patient record including the most important images is technical ready. The other day these cards will contain also the application programs, so that the computer programs at the Doctor's Office Computer must not be standardized (Zimpelmann, 1995). That sound a bit utopican, but a Hybrid Card system will be presented at the Health Card '95 in October in Frankfurt.

5 WHICH RESULTS ARE TO BE EXPECTED

One development which is already to be seen, (Zimpelmann, 1995[2]) concerned the notion healthiness and illness. The borderline between these two situations had been week for Thousands of years, now it is vanishing almost totally. The digital classification ill and not ill will be replaced by a qualitative description of acceptance of life, of feeling well, of taking into account, of satisfaction (Köhler, 1995), (McDonald, 1994), (Weed, 1970).

This development will be supported by gaining the above described goals and supports at the same time the gaining of the goals. The satisfaction of all persons concerned within the health care system will be a very simple but immense important item of the 'new' health care system. Out of this satisfaction results more or less compulsorily the wishes to increase this satisfaction, that leads automatically to a better motivation of all persons concerned - including the patients.

Higher satisfaction and better motivation leads also automatically to better quality of medical actions. The increasing of quality will have the effects on process and result quality (Donabedian, 1988), (Falvo, Woelhke, Deichmann, 1995).

One of the largest problems within health care systems in almost all countries is the dramatically increasing of costs. The solution of this problem stands on first place for many people of health care politics, insurances and all kinds of associations. They must accept that better quality means at the same time decreasing costs. Money be put into quality pays back twice. We all would be happy already if the costs in health care will not increase further on.

That model, described here within the 'results' seems to be too simple, but looking at the few figures above it is to be seen that it is not simple at all and very complex. The model could not be realized in one but only step by step in kind of a mosaic. Not one person is able to change the world, but many people could produce an atmosphere in which the world could be changed.

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