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Why is Hippocrates Crying? An American Perspective

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Most healthcare professionals are familiar with Hippocrates' name, but they probably know little about him. A Greek physician who lived over 2,400 years ago, he is still viewed as one of the most outstanding figures in the history of medicine. Often, both medical and nursing students agree to abide by the Hippocratic Oath. While he may be best known for his admonition "First, do no harm," there remains debate about its origin . Nonetheless, most clinicians would agree this threshold is much too low.

Although Hippocrates focused on individual behavior, avoiding preventable harm is also an obligation of healthcare organizations. This article will focus on four major challenges confronting the American health system: 1) the lack of consistent affordability, accessibility, and quality, 2) racial and ethnic inequities, 3) professional burnout and violence against hospital staff, and 4) the failure to sufficiently address social determinants of health to improve community health status. Despite these legitimate concerns, based on a review of the literature, there are reasons for cautious optimism.

Healthcare Organizations Should Be Responsible for Preventing Avoidable Harm

Although Hippocrates focused on individual behavior, avoiding preventable harm is also an obligation of healthcare organizations.

1. Unfortunately, when looking objectively at the United States (U.S.) health system, most Americans agree that the lack of consistent affordability, accessibility, and quality is a serious problem. More than 5,000 Americans were asked to grade the U.S. healthcare system overall and regarding affordability, accessibility, and quality. Overall, 44% graded the entire system as poor or failing, and one in three assigned an F to healthcare affordability [2]. A Commonwealth Fund study found our health system ranks last on quality and accessible care among 11 high income countries [3]. Earlier this year, a writer for CNN Health, summarized the findings of another report from the Commonwealth Fund. She noted, "The United States spends more on health care than any other high-income country but still has the lowest life expectancy at birth and the highest rate of people with multiple chronic diseases. Compared with peer nations, the U.S. has the highest rates of deaths from avoidable or treatable causes and the highest maternal and infant death rates" [4].

We also know two-thirds of all personal bankruptcies in the U.S. are due to medical bills [5]. A Kaiser Family Foundation analysis noted that nearly one in 10 adults has medical debt" [6]. Delaying treatment due to current medical debt remains a significant problem, frequently resulting in patients needing more expensive treatment when they go to the emergency department or require hospitalization. The distressing impact from the growing number of people experiencing personal bankruptcy due to an inability to pay medical bills is indisputable. There is a remarkable $88 billion in medical bills on credit reports, according to the Consumer Financial Protection Bureau [7].

Data from the Centers for Disease Control and Protection documents that hospital-acquired infections in America affected one out of every 31 patients, caused 72,000 deaths, and led to billions in direct costs every year. The overall economic burden hospitals face due to these infections ranges from $28-45 billion, according to the CDC [8] .

Despite these legitimate concerns, progress is being made. United Regional Health Care in Texas has had good results from a digital health program that tracks patient engagement and promotes targeted resources and interactions to address care gaps and costs. With a special focus on patients with chronic conditions, such as diabetes affecting more than 34 million Americans, the goal is to "maximize preventive care and minimize unnecessary use of costly emergency department visits and hospitalizations" [9]. In a letter to the editor of the Washington Post, Rick Pollack, president of the American Hospital Association, stated, "The last thing that hospitals want is for their patients to face financial barriers. That's why hospitals go to great lengths to help patients understand their health coverage and financial obligations for care, which is based, in large part, on their insurance. Most hospitals provide free care for patients with the most limited means." He added, "Hospitals of all types have provided almost $745 billion in care since 2000 for which they received no payment" [10].

- Healthcare acquired infections have received increasingly effective attention. A U.S. report, "National HAI Targets and Metrics," was issued by the U.S. Department of Health and Human Resources. Progress in reducing the six most

common infections was compared from 2015 to 2020 by the U.S. Department of Health and Human Services. The Central line-associated bloodstream infections in intensive care units and ward-located patients fell by 50 percent.

- Catheter-associated urinary tracts infections in intensive care units and ward-located patients dropped by 25 percent.
- Invasive healthcare-associated methicillin-resistant Staphylococcus aureus (MRSA) infections decreased by 50 percent.
- Hospital-onset MRSA bloodstream infections went down by 50 percent.
- Hospital-onset *Clostridioides difficile* infections (CDI) were lower by 30 percent as were *Clostridioides difficile* hospitalizations.
- Surgical site infections were also reduced by 30 percent [11].

2. Racial and ethnic inequities remain a major stain on this country's clinical treatment of minorities. The Agency for Healthcare Research and Quality's latest National Healthcare Quality and Disparities Report found that Blacks, American Indians, Alaskan Natives, and Hispanics receive worse medical care than white patients [12]. Furthermore, a report by the Commonwealth Fund demonstrated the persistence of these racial and ethnic disparities across all U.S. geographic regions [13]. Kevin Nguyen and his colleagues studied whether patients in one Medicaid managed-care plan from ethnic minority groups received the same care as their white peers. They examined four areas: access to needed care, access to a personal doctor, timely access to a checkup or routine care, and timely access to specialty care. As might be expected, he found Black beneficiaries; Asian American, Native Hawaiian, and Pacific Islander beneficiaries; and Hispanic or Latino/Latinx beneficiaries reported worse experiences across the four measures [14]. Although he did not collect responses from LBGQT patients, it would not be surprising if they also had worse experiences in the same four areas.

Substantially reducing racial and ethnic inequities is still a massive challenge, but meaningful progress has been made here too. More hospitals and health systems are participating in and being recognized by the AHA's Equity of Care awards program [15]. Minneapolis-based HealthPartners, which has been stratifying its patients' experiences and outcomes by race and ethnicity for more than 15 years, deserves more attention than it has received [16]. Yet another example requiring greater awareness is Kaiser Permanente's success in improving control of chronic conditions among minority patients [17]. The work of Point32Health deserves mention too. It has over 70 ongoing health equity initiatives established in collaboration with the Harvard Pilgram Health Plan and the Tufts Health Plan which together involve two million members [18].

"The Anchor Strategy – A Place-Based Business Approach for Health Equity," was published earlier this year in the New England Journal of Medicine. The article described how the Rush University for Health and West Side United (WSU) created the Healthcare Anchor Network (HAN) and responded to the disproportionate burden of the COVID-19 pandemic on Chicago's Black and Latinx communities. WSU managed the distribution of $6.9 million in relief dollars to more than 35 community organizations in 23 Chicago communities. In response to the racial disparity in COVID-19 mortality and to the murder of George Floyd in May 2020, a Racial Equity Rapid Response Team had 36 healthcare members publish a statement declaring racism a public health crisis and outlining commitments to address systemic racism – a statement that was subsequently adopted by 40 HAN health systems nationwide [19].

It is also noteworthy that The Hasting Center's 2023 annual report was titled "Advancing Health Equity." This report indicated "The Hastings Center and the Association of American Medical Colleges Center for Health Justice convened a two-day health equity summit called 'Righting the Wrongs: Tackling Health Inequities.'" Co-sponsors included the American Medical Association, the American Nurses Association, the American Board of Internal Medicine Foundation, and the American Hospital Association. Approximately 2,500 people attended remotely [20].

3. Both professional burnout and violence against hospital staff have become ubiquitous. Professional burnout is generally viewed as emotional exhaustion and affects both physicians and nurses, as well as other clinicians. We know it can lead to clinical errors, moral distress, depression, early retirement, and provider suicide. "Nurses Are Burned Out and Fed Up, with Good Reason" appeared in the New York Times [21]. And a survey shows doctor burnout and depression is getting worse [22]. Describing eloquently how practicing medicine had become an "unbearable strain," an anonymous physician discussed the reasons why [23]. Healthcare workers are also encountering more violence. The U.S. Bureau of Labor Statistics indicates healthcare workers accounted for 73 percent of all nonfatal workplace injuries and illnesses due to violence. Their data show the industry's number of total workplace violence has grown every year since 2011, the first year the new event classification was used [24]. A recent report indicated American healthcare workers now suffer more nonfatal injuries from workplace violence than workers in any other profession, including law enforcement [25].

Improvements in this area have been made as well. "Battling Clinician Burnout." focused primarily on the outstanding work for almost 20 years of Stanford Health's chief wellness officer Tait Shanafelt, MD. In addition, the contributions of University of Alabama Medicine, the American Nursing Association, Hennepin Healthcare in Minneapolis, and Atrius Healthcare in Newton, Massachusetts were summarized [26]. Also noteworthy is a new set of 12 recommendations for responding to moral distress in clinical practice, published by The Hastings Center Report [27].

To address the increasing violence against healthcare workers, Massachusetts General Brigham's website reported that a patient code of conduct was instituted to make clear that discriminatory and harassing behavior will not be tolerated. The code of conduct prohibits physical or verbal threats; offensive comments about someone's race, accent, religion, gender, or sexual orientation; refusing to see a hospital employee because of such personal traits; sexual or vulgar actions or words; and disrupting the care or experience of another patient. According to the organization, any patient who engages in such behavior will be given a chance to 'explain [their] point of view,' but such conduct could result in the patient no longer being welcome at the institution [28]. Nearly 40 states have established or increased penalties for assaults on healthcare workers [29]. An issue of AHA Today included a case study of the New York-Presbyterian Health System's efforts to prevent and mitigate workplace violence. The same issue reported on how Connecticut-based Bristol Health greatly reduced violent incidents within three years and the steps taken by Georgia-based Grady Health System to train all staff in de-escalation, self-defense, and response to emergency codes when they are hired and annually, along with any changes in the interim [30]. Most recently, the board of the American Hospital Association has distributed "Building a Safe Workplace and Community: A Framework" to all institutional and personal members [31].

4. Institutional providers are not doing enough to address social factors affecting health to improve community health status. This topic was eloquently discussed by a physician who wrote "Doctors have their own diagnosis: 'moral distress' from an inhumane health system" [32]. As in some other countries, we realize that substandard housing, food insecurity, and violence are prevalent in many of our communities. Another physician titled his article "Deaths of despair: an urgent call for a collective response to the crisis in U.S. life expectancy." He acknowledged deaths of despair was the term used for deaths attributed to suicide, drug overdoses, and alcohol-related disease coined by Princeton economists Anne Case and Angus Deaton [33].

Yet again, notable progress has been made in dealing with social factors affecting health. Several healthcare organizations have been cited for their innovative efforts. For example, Guadalupe County Hospital in eastern New Mexico "has set up school-based health clinics to provide preventive care for students, increasing access to quality health care services for children and families in remote rural areas." Norman Regional Health System in central Oklahoma was recognized for "improving the health of communities outside of its hospitals' walls through its food pharmacy, community health navigator program and Community Call Center and by administering flu and COVID-19 vaccines" [34]. The senior director of Community and Population Health at Chicago-based CommonSpirit Health has discussed how competing health systems, payers, and community health organizations joined together to provide care for the most high-risk populations. Not only has CommonSpirit Health invested $1.1 million into this novel new program, but it has also raised $3.4 million from other healthcare organizations, including 11 payers. The populations served are predominantly Medicaid recipients, and the participating organizations have specifically selected populations that have been most difficult to reach [35].

In "How Do We Fix the Scandal that Is American Health Care?" Nicholas Kristof, winner of two Pulitzer Prizes, notes "Americans are among the least healthy people in the rich world, and among the most likely to die early" [36]. His proposed solutions are similar to the ones referenced in this article.

CONCLUDING OBSERVATIONS

If Hippocrates were alive today, he would be weeping. He would be in despair because comprehensive hospital price transparency is still more of a myth than reality and distressed by the awesome power of pharmaceutical companies' ability to effectively minimize the government's ability to negotiate drug prices.

He would be even more upset with the September 2023 report by The President's Council of Advisors on Science and Technology. In its 34-page report, the authors wrote: ". . . dangerous and preventable events continue to occur at surprisingly high rates. According to recent data, in the United States, Medicare patients suffer an adverse event in one out of four hospitalizations. One third of those adverse events are serious, including catastrophic outcomes. Consistent with observations noted in other areas of health care, adverse outcomes disproportionately impact people from groups historically experiencing social marginalization, widening gaps in healthcare disparities" [37].

Admittedly, much work remains to be done. It should be noted that even achieving agreement on terminology is problematic as well-documented in a recent article which described a fundamental misunderstanding among staff members about the difference between health inequalities and health inequities at Grady Health System, one of the most progressive safety net health systems in the country [38]. More healthcare organizations should replicate best practices demonstrated by institutions which have had an impressive impact on improving affordability, accessibility, and quality. As mentioned previously, there are also laudable examples of institutions which have reduced inequities, prevented avoidable harm to patients, their families, and staff members, and some which are successfully tackling social factors adversely affecting health status. In addition, other organizations which have achieved well-documented success in any of these areas should publish their findings and present them at local, state, and national conferences. Finally, too many American hospitals and health systems rely exclusively on what has been publicized in the U.S. By not capitalizing on what has been accomplished in other countries, we are missing opportunities to accelerate improvements in all four areas [39].

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