# You Can't Leap a Chasm in Two Jumps: The Institute of Medicine Health Care Quality Report

GORDON D. SCHIFF, MD[a]
QUENTIN D. YOUNG, MD[b]

*The American health system is in need of fundamental change. It is failing both clinicians and patients, and their frustration levels have never been higher . . . .*[1] *[p. 1]*

*Exhaustive research now shows that the system is plagued with errors, over-utilization, and under-utilization. These problems are not the result of a failure of goodwill, knowledge, effort, or resources devoted to healthcare—they stem from fundamental shortcomings in the way the system is organized.*[1] *[p. 25-26]*

*The current system will not work to achieve the enormous changes that are needed.*[1] *[p. 95]*

*Correction of the problems [in the system] calls for fundamental changes in the organization, delivery and financing of the US health system.*[1] *[p. 24]*

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With language that could easily have been lifted from a radical manifesto for national health reform,[2] the prestigious Institute of Medicine (IOM) Committee on Quality of Health Care in America has issued a scathing indictment of the US health care system. According to the IOM Committee, the magnitude of the disparity between "the health care we have [and] the care we could have . . . is a not just a gap, but a chasm"[1] (p.1). Hence the provocative title of the Committee's second and final report, *Crossing the Quality Chasm: A New Health System for the 21st Century.*

This new publication, released a year after the Committee's influential first report, *To Err is Human: Building a Safer Health System,*[3] aims, like its predecessor, to have a major impact on public opinion and health policy. While much of the publicity generated by *To Err is Human* centered around its spotlighting of a decade-old finding that medical errors caused as many as 98,000 deaths each

[a]Department of Medicine, Cook County Hospital, and Department of Medicine, Rush Medical College, Chicago, IL

[b]Health and Medicine Policy Research Group, and Department of Preventive Medicine, School of Medicine, University of Illinois at Chicago, Chicago, IL

Address correspondence to: Gordon D. Schiff, MD, Dept. of Medicine, Cook County Hospital, 1900 W. Polk St., Rm. 901-AX, Chicago, IL 60612; tel. 312-633-6905; fax 312-633-3684; e-mail <gdschiff@aol.com>.

year, its excellent and practical recommendations (presented in Chapter 8: "Creating Safety Systems in Health Care Organizations") remain largely unheeded.

Nonetheless, this second report boldly goes further. It characterizes the serious problem of medical errors as the "tip of the iceberg," and only "a small part of the unfolding story of quality" problems. Other defects "are even more widespread" and "taken together detract still further from the health, functioning, dignity, comfort, satisfaction, and resources of Americans"[1] (p. 2).

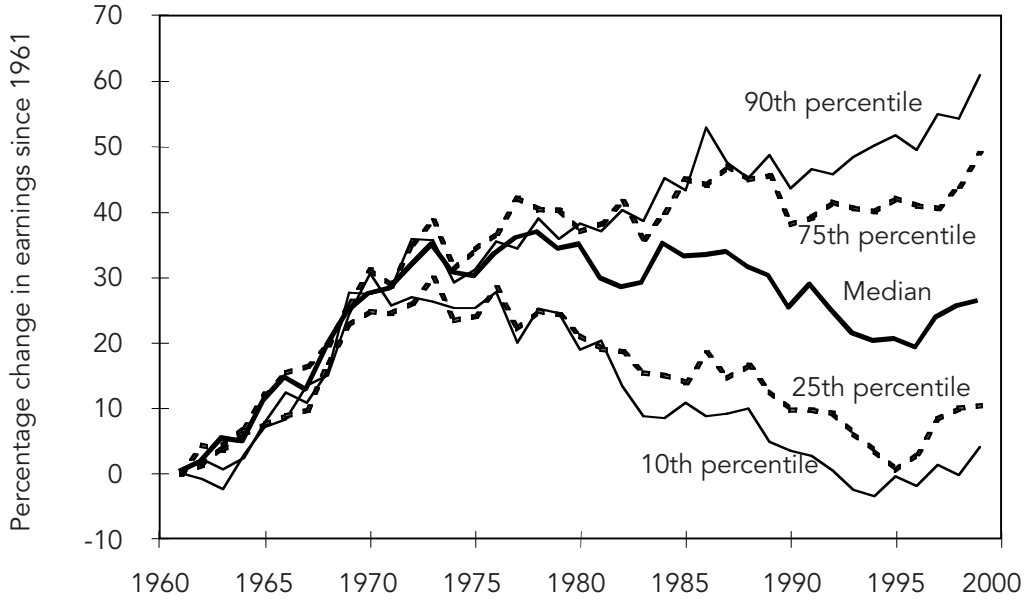
**Bigger Gaps: The Uninsured**

In thinking about the relationship between the IOM report and the theme for this special issue of *Public Health Reports* highlighting health disparities, we are struck by a variety of gaps, many even wider than, although closely related to, the health services quality gaps that the *Quality Chasm* report details. While the authors mention the need for equity as one of their six aims for an improved health system, it receives scant attention. Equity gets less than half the space given in the report to, for example, regulation of professionals, or making information available on the Internet. Yet the relationship between quality and inequality is so profound that anyone serious about grappling with quality must address it. Given the growing evidence relating health services processes and outcomes to income, "race," and insurance status, any meaningful effort to improve quality must address the sources of these inequalities.

Without a more equitable system, "highest quality care" will continue to be confused with preferential treatment in a marketplace that allocates multi-tiered care based on ability to pay.[4] Health care reform proposals such as medical savings accounts, tax credits, tiered benefits, and tiered formulary packages promoted by both the Republican and Democratic parties, purportedly designed to make patients more "cost-conscious" depending on their willingness to pay more if they want more expensive care, actually are rationing quality according to ability to pay. Ponder what this means in an era of unprecedented widening of income inequalities[5] (see Figure), as income inequities are translated, by design, into care inequities.

There is thus a worrisome gap between the IOM Committee's laudable ideals and recommendations and the reality of contemporary health care. Without a universal national health insurance plan as a starting point to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable—the Committee's six goals for improvement—these laudable

**Figure. Growing income chasm: distribution of real wage and salary earnings for full-year, full-time male workers ages 16–64**




SOURCE: Reference 5

aims are seriously handicapped. As the reports' authors admit, "equity in care implies universal access, a promise that has yet to be either made or kept"[1] (p. 55).

Without a guaranteed right to health care, other quality goals will be difficult to address, let alone achieve.[4] These broader goals are continually moved to the periphery as increasing rates of uninsurance and underinsurance make quality a remote concern for people who can't even get their foot in the door. Further, much activity organized under the rubric of patients' rights and quality improvement represents wasted energy—"getting a foot-in-the-door" access issues for those who *are* insured and their providers[6]: fighting to get access to timely appointments and phone consultations; tussling over access to tests and consultations; arguing over conflicting formularies; struggling to locate basic information on patients who have had to switch providers; clashing over which patients are insured with what coverage for how long and what happens when they change jobs, income categories, age groups, or have serious or chronic "preexisting" illnesses.

The resources squandered on these non-health-enhancing friction-generating activities are enormous. Such impediments would all be non-issues in a system of universal coverage with clear uniform standards and protections. And, a simple, uniform and equitable system would significantly enhance the resources available to address the real nitty-gritty issues of assessing and improving the quality of the actual care delivered

**Chronically Ill Patients: Hot Potatoes or Highest Priority?**

It is ironic that the Committee chose to focus on patients with chronic diseases: "Chronic diseases should serve as a starting point for the restructuring of health care delivery because chronic conditions are the leading cause of illness, disability, and death in the US, affecting almost half of the population and accounting for the majority of health care resources used"[1] (p. 95). The Committee urges the identification of 15 priority chronic conditions around which the nation can forge a sense of unifying purpose, which will provide concrete focus for the application of "10 new rules" for system redesign (see Table).

While the authors illustrate how today's health system is "not well designed" for patients with chronic conditions (fragmented uncoordinated care; poor communication between patients and caregivers; unmet needs), they fail to emphasize how chronically ill people are the untouchables in our present private insurance system. Despite reams of rhetoric from managed care companies about chronic disease management programs, the reality is that profits come from enrolling healthy people and avoiding sick people. Actuaries, not actual clinicians, call the shots, as they work to identify and exclude the 5% of the population with chronic and complex illnesses who account for the majority (55%) of health care costs.[7] When individual patients, specific sectors, or whole communities are found to be unprofitable (as has happened with the 1.7 million seniors dumped from Medicare managed care over the past four years),[8,9] they are tossed out.

Moving chronically ill patients from untouchable hot potatoes to highest priority for care will take more than merely fine-tuning payment techniques, as Medicare is attempting to do in risk-adjusting reimbursement rates. Rather, it calls for renewed emphasis on professional and caring relationships—relationships that have been devalued in our current profit-driven system.[10] All of the unmeasured and immeasurable ways in which patients and providers can be rewarded when they work together to deal with illness will have to form the foundation of these caring relationships. And these relationships will need to be based on something more than mutual striving for the best financial deal.[11]

**Aligning Incentives with Quality**

Instead of calling for (or even mentioning this as an option) redesign of health care financing to make it fairer, simpler, and more efficient via a single-payer universal system, Chapter 8 of *this* IOM report (titled "Alignment of Payment Policies with Quality Improvement") disappointingly dwells on tinkering with the ways physicians and plans are paid. Acknowledging that current payment formulae pose obstacles to quality improvement, the authors seek ways to recognize, reward, and support quality improvement[1] (p. 194). In contrast to the bold ideas that characterize other sections of the report, here we find a narrow and, frankly, all-too-familiar discussion of capitation vs fee-for-service.

It has become a truism (if for no other reason than sheer repetition) that fee-for-service and at-risk capitation are two sides of the same coin. Fee-for-service is seen as promoting overuse while capitation promotes underuse. The two are supposedly symmetrical in their pluses and minuses. This formulation, echoed in the IOM report, usually ends up justifying the cost-cutting exigencies of managed care, since there is a need to hold down costs and the alternative to managed care, fee-for-service, is seen as subjecting patients to unnecessary tests and procedures.

However, in current health care practice, this symmetry is a myth. Risk capitation closely mirrors fee-for-service *with kickback schemes,* in which, for instance, a

**Table. Friction vs traction: barriers and facilitators to IOM's 10 "new rules" to transform health care**

| *New rules to improve care, adapted from IOM report*[1] | *Inhibitors/barriers in current market-oriented system* | *Facilitators/motivators in a public, universal system* |
|---|---|---|
| 1. Care based on continuous healing relationships; 24-7 access/ responsiveness; minimize unneeded face-to-face visits. | • Disruptions in continuity (resulting from, e.g., annual employer bids for best deal, monthly Medicaid eligibility changes, S-CHIP enrollment contingent on fluctuating eligibility[23,24]).<br>• Barriers (including financial) to access fueling cycle of anxiety, more demand, more barriers, and so on. | • Stable funding, with no requirement to switch providers for reasons other than patient choice.<br>• Public accountability for access/ conveniences.<br>• Public health approach to decrease unnecessary encounters.<br>• Fewer incentives for wasteful encounters. |
| 2. Customization based on patient needs; patient values drive variations. | • Emphasis on brands and branding for product differentiation, giving illusion of marketplace choices, often without independent, comparative evidence on which to base decisions.<br>• New technology promoted/favored over more careful fine-tuning of skills, processes, interactions. | • Research and improvement efforts facilitated (e.g., research with Medicare database for prostatic hypertrophy shared decision-making paradigm).[25]<br>• Mobility and portability to achieve best-fit relationships; trusting environment would enable healthier transactions.[26] |
| 3. Patient as source of control. | • One dollar, one vote: profit-driven institutions cater to rich and well-insured and neglect others.<br>• Locus of decision-making shifted away from primary care relationships and local communities to distant corporate headquarters. | • More democratic local control of direction of resources and system.<br>• Ultimate accountability is to patient/ public, not stock owners. |
| 4. Shared knowledge; free flow of information. | • Protection of proprietary information.<br>• Inhibitions on public release of negative information or suppression of research studies to protect corporate image or profits.[21]<br>• Modes of reimbursement and the decision-making process itself concealed.<br>• Ad hoc purchasing of computer software/systems fragments information. | • Favors open source information/ systems.<br>• Non-proprietary approach to information (e.g., PubMed; journals such as *British Medical Journal* free on Web).<br>• Traditions of right to information, epidemiologic reporting, availability of claims data.<br>• Information sharing facilitated by public standards for confidentiality, storage, and release. |
| 5. Evidence based decision-making. | • Primary data often withheld or transformed into proprietary data.<br>• Marketing and promotion encourages one-sided education and stimulates excess demand.[27,28]<br>• Information flow and practice conditioned by market considerations such as pressures to quickly reap returns on drug research investments. | • Independent consensus evaluative review processes and forums (NIH Consensus Conferences, professional society recommendations, AHRQ guidelines).<br>• Better insulated from market biases. |
| 6. Safety as a system property. | • Temptation for profit motivation to compromise staffing and safety standards.[29]<br>• Short-term rewards from stretching and stressing staff more lucrative than long-term improvement/investment. | • Public safety as historic goal of public service and agencies (e.g., EPA, FAA, OSHA, NHTSA).<br>• Leading role of not-for-profits and government sector in current safety movement (AHRQ, CMS, USP, VA hospitals). |

(continued)

**Table. (continued)**

| *New rules to improve care, adapted from IOM report*[1] | *Inhibitors/barriers in current market-oriented system* | *Facilitators/motivators in a public, universal system* |
|---|---|---|
| 7. Need for transparency. | • Numerous incentives and mechanisms to conceal (noted above). | • Public sector by definition is public, with oversight from citizens, volunteer groups, and publicly elected officials.<br>• Decision-making points and processes identifiable. |
| 8. Anticipate needs. | • Needs of profit-making predominate and shape planning and policy.<br>• Fragmentation of community as obstacle to population-based practice.[30] | • The essence of public health practice, which is steeped in principles of epidemiology, outcomes research, health planning, workforce training, and resource allocation.<br>• Some positive experience attempting to constrain excessive/imbalanced capital allocation. |
| 9. Waste continuously decreased. | • Massive unmeasured private sector waste buried in accounting systems that measure only selected costs (e.g., staffing costs), externalizing others (environmental impacts).<br>• Administrative/marketing waste.[31]<br>• Unconscionable executive rewards.<br>• Frills contrasted to frugality of public sector. | • An ongoing challenge. |
| 10. Cooperation. | • Enshrines competitiveness and selfishness as desired engines of improvement, as if all progress depends on humans being acquisitive, individualistic, aggressive, and on the strong displacing the weak.[32] | • Based on and encourages a non-market, more cooperative value system.[33,34]<br>• Better balance of collective and individual needs; orientation around collective progress, group and cooperative caring endeavor, and public service. |

AHRQ = Agency for Healthcare Research and Quality
CMS = Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration)
EPA = Environmental Protection Agency
FAA = Federal Aviation Administration
IOM = Institute of Medicine
NHTSA = National Highway Traffic Safety Administration
NIH = National Institutes of Health
OSHA = Occupational Safety and Health Administration
S-CHIP = State Children's Health Insurance Program
USP = United States Pharmacopoeia
VA = Veterans Administration

physician ordering a CT scan would get a share of the money generated by the referral—clearly a powerful, unethical, and (now) illegal inducement to over-order scans. This is the true parallel with at-risk capitated managed care, in which there is a similar financial bonus for *not* ordering the scan.

The "two sides of the coin" formulation also fails to account for information asymmetries. Patients may lack knowledge of referrals indicated but not ordered under capitation, whereas they always know of referrals made under fee-for-service and can question their appropriateness. Likewise, a claims database that keeps

track of fee-for-service billing transactions can be used to monitor variations and excessive use. Many invaluable health services research and quality improvement initiatives have derived from Medicare and Medicaid claims databases.[12,13] There is no comparable trail of services forgone (or sometimes provided needlessly) under managed care.

Finally, the traditional fee-for-service model better aligns (albeit imperfectly) the interests of physician and patient in ways that promote trust, continuity, and incentives to satisfy the patient. Conversely, the most poisonous aspect of marketplace managed care is the creation of a distrustful and adversarial relationship in the exam room. Patients, regularly forced to switch physicians by employers annually bargaining for a few dollars of premium discounts, wonder whether they can trust unfamiliar doctors incentivized to deny care.[6] Meanwhile, physicians gamble by contracting to cover more "lives," speculating that they can turn a profit if they can recruit enough healthy patients, while dreading getting stuck with sick or costly ones.[14]

It is therefore hardly surprising to find that chronically ill patients have repeatedly been shown to be less satisfied and do worse under capitated schemes than under traditional insurance arrangements.[15] Yet the sick poor, who are disproportionately disadvantaged members of minority groups who have worse health outcomes under managed care than under fee-for-service,[16] are being pushed into capitated managed care. Meanwhile, more responsive arrangements (such as preferred provider organizations) are on the rise for those chronically ill people who can afford to choose their desired plans.

We are not arguing for return to unbridled fee-for-service, nor denying the value of experimenting with some of the Committee's recommended "blended" payment approaches to encourage quality improvement. But the whole fee-for-service vs capitation discussion is predicated on the belief that greed must be the defining factor in doctors' conduct, and that by manipulating payments, we can somehow "align incentives" with market forces and this will magically produce quality. The real problem is not that the current incentives are skewed, but that the entire orientation around monetary gains and games is misdirected. Only by tapping into clinicians' immense reservoir of professionalism, and developing a culture and infrastructure that sustain rigorous science and caring relationships, will quality flourish.[10,17] Nurses and doctors need support in the form of time, training, accessible information, and practical timely guidance, not better carrots or sticks. As Don Berwick, one of the principal authors of the IOM *Chasm* report recently stated, professionals stuck in older, less innovative ways of practicing are not *resisting* change, they are *predicting* its unworkability under the current system.[18]

**What *Is* the Problem?**

The IOM Committee clearly understands that more fundamental changes are needed, yet seems unwilling to name a central problem eroding quality—the transformation of health care from a service into a business.[19] This transformation has recently been characterized by former editors of two leading US medical journals as "the invasion of medicine by commercial interests, now on a global scale"[20] such that care is delivered by organizations that "behave as though their only responsibility is to their shareholders."[21] Necessary functions such as ensuring uniformly good care for anyone anywhere in the nation, or obtaining money for investment in information technology, do not require, as market advocates have argued, turning the system over to national corporate chains or institutions abandoning their not-for-profit status/mission to attract investor capital. Unfortunately, this is exactly what is occurring. Thus, while the IOM report sounds the alarm about the serious state of quality in health care, the very factors that underlie impaired quality and make the system (in the IOM Committee's words) "a nightmare to navigate" will also mitigate against the success of the report's recommendations for change.

Eight of the IOM Committee's 13 recommendations call for an expanded role for public sector leadership to support quality improvement. For the public sector to succeed in the roles outlined by the Committee, there must be both a mandate and a mechanism. Each of these prerequisites is now being undermined by corporate America. Many with economically vested interests have worked to demonize "government" and push aside public accountability and oversight (for instance, attempting to beat back even the most tepid Patient Bill of Rights legislation). While the IOM Committee calls for an active role for public institutions representing our collective interests in better quality, absent a shift in the balance of power, their appeals are likely to fail. (See Table.)

"Less government" in our $1.4 trillion health care sector really means "more corporate power," which translates into more inequality, more impersonal organizations and care, and less transparency and accountability. These are all ingredients for poorer quality, as we understand the Committee's recipes. Corporate ascendancy in health care destroys continuity relationships with providers and institutions, erodes charitable practices, narrows channels for open communication and nonproprietary sharing of information, demoral-

izes providers, and ultimately poisons professional dedication to the patient rather than to the bottom line.

There was plenty of self-interested abuse under traditional medicine, but it occurred when practitioners strayed outside the realm of their professional oaths. If the goal of medicine is reduced to maximizing shareholder return, then financial self-interest becomes not an ethical violation, but the norm—a standard expected practice.[22] When physicians are incentivized with "at-risk" capitated arrangements, unethical conflicts occur by design. When tests, treatments, and referrals are held back, the patient takes a risk, yet it is the physician or plan that reaps the benefit.

In emphasizing the need to shift power from providers to patients, the IOM authors fail to address the more profound power shifts that are occurring in our society—shifts that will actually require alliances between patients and providers to prevent further erosion in the social fabric from which good health care springs. We are living in a society increasingly divided between rich stockholders (who view health care as a source of profit) and the rest of us, who view health services as a source of care. This chasm can only be bridged when we not only change the rules of the game but also recognize that sickness and suffering are the wrong venue for playing such a game in the first place.

To their credit, the members of the IOM panel did not get blown off course by the winds of marketplace pseudo-quality (e.g., report cards; brand-name, advertising-imprinted institutional reputations; special programs never implemented beyond the pilot stage; self-interested utilization reviews; or the lure of new drugs and technology). Their report does chart a new course for us to follow. However, sailing upstream requires a mobilized public that both understands the causes of the problems and is organized for change. Empowering patients thus requires giving them a voice, a vote, and a higher vision than bottom-line medicine is offering.

We indeed have a chasm to cross. With the current emphasis on incrementalism, many reformers believe they can succeed by first attending to quality and then reforming financing and delivery. Unfortunately, you can not bridge a chasm in two jumps—health system reform must be pursued at the same time as quality reform.[19] And you can not bridge the gap between black and white or rich and poor health care by creating separate or stratified programs (which both Republicans and Democrats are proposing) based on ability to pay. Instead, we need a universal financing system that includes everyone, spreading the costs and the benefits in a fair and efficient way. "Everyone in and nobody out" has become a rallying cry for reform of our health system, and it beckons those seeking to improve its quality as well.

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