North Coast Physician

In This Issue:

Cover Photo
"BULL ELK PORTRAIT 1"
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North Coast Physician is published monthly by the **Humboldt-Del Norte County Medical Society**, 3100 Edgewood Road, P.O. Box 6457, Eureka, CA 95502. Telephone: (707) 442-2367; FAX: (707) 442-8134; E-Mail: hdncms@gmail.com
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In My Opinion

"One day about 25 years from now/ When we've all grown older from a'wondering how/ Oh we'll all sit down by the city dump/ And talk about the Goodle Days./ Oh, you'll pass the joint and I'll pass the wine/ And anything good from a'down the line/ A lot of good things went down one time/ Back in the Goodle Days."----*John Hartford, 1971 (Aereo-Plane album)*

John Hartford was a remarkable musician; he lived in Madison Tennessee, across the river and across the county from where I grew up (or failed to do so, if you ask The Better Half) in the southern portion of Nashville/Davidson County, Tennessee. I never met him personally, and I was much more of a classical music enthusiast than his "Newgrass" style, but the Aereo-Plain album came out just over 50 years ago, and I fell in love with it and still remember almost all the lyrics from all the songs. It is worth a listen.

What brought that to mind, as well as the title of this little essay, is what has happened to medicine in the 45 years (next Spring) since I graduated with my MD from Stanford. At that time, although there was no shortage of complaints about the cost of medical care, which at the time amounted to about 6% of GDP. Well, as one might surmise, it has gone up a lot since, now over 19% of GDP, over a threefold increase. One might therefore think that physicians' portion of the health care expense pie would have concomitantly increased, but that is definitely untrue. In fact, compared to overall expense on medical care issues, physician compensation has been pretty flat, while all other curves are steeply climbing.

It will of course be said that the other expenses are higher because we have a lot more that can be done for conditions, often fatal in days of yore, that now are treatable, even in many instances curable. The revolution in cancer care is a good example. And, while HIV/AIDS was just over the horizon, what was initially a uniformly fatal disease is now manageable as a chronic illness. Obesity, and its constant companion diabetes, are much more rampant, and thus more expensive, not to mention that there are a whole bunch of management options for that disease than were available back then. And, of course, the Pharmaceutical industry is a potent power with the ability to charge unheard-of prices for the benefits that they can provide.

When I moved here in 1997, it was commonplace that the primary care physician (and it was ALWAYS A PHYSICIAN, and who were really good assistants and good at it), was available not only to follow a hospitalized patient, but also to scrub into the operation. That gave him or her the opportunity to participate in management decisions, to more clearly understand what the pathology was and how it would integrate into the overall management, but it was also a way to compare notes, and to reassure the patient that he or she was being cared for by someone who really was interested in their overall well-being, and who understood who the patient was, with whom they lived, what their occupation and social situation was, and much more. (I have long contended that the social history is one of the most important items in the patient's history and physical, but attention to that has suffered greatly in recent years.)

Why has this happened? And, not incidentally, why are so many physicians becoming disenchanted with medical practice, to the point that it is estimated that some 20% of current doctors will be leaving practice in the next two years?

I think that if you were to ask patients what they want in a physician, and in medical care in general, they would offer some version of this: they want someone who knows them, understands their situation and their needs, and who will be there for the important medical issues and crises, to which at one time or another all of us will be exposed. Someone like Dr. Marcus Welby. Now, I will admit that I didn't watch the show (in fact, in general I have avoided "doctor shows" because they generally don't reflect what we do and are often more crisis oriented than our daily experience; but then again, so are "cop shows", Westerns, etc etc; what they show is drama in short and well-formed aliquots.) But, one feature of this show was that Dr. Welby knew his patients well, and wanted them to "Be-Well" (as a punster, I can appreciate the nomenclature). What he offered was compassion. And a sympathetic ear and voice who could participate and help with the vicissitudes and crises of life.

But nowadays, this type of longitudinal orientation is honored mostly in the breach rather than the observance. Independent primary medical and specialty practices are atomized to the point that many, if not most, patients can't really name the person (physician or "physician extender") who is in charge of their care overall. I think this leads to alienation, which then leads to reliance on "Dr. Google". There is some definite good in the patient education that offers, but also much confusion and fear. And the fact that patients are given their imaging and test results before the physician only exacerbates that problem.

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"WELBY", Continued From Pg 4

Well, I can think of a couple of important issues driving this trend. One is that reimbursement for medical care has changed radically in the past 50 years or so. Before Medicare, Medicaid, and the Blues and their numerous successors, a physician would name a charge for their services, and expect that it would be paid. Kind of like what happens when we take Fido to the veterinarian. Or most of us when we go to the dentist. The advent of health "insurance" (a misnomer, in my view), third party payers, and the decoupling of the service from the bills rendered, makes it seem that any charge is more than needed or fair. And today, that is probably true in many instances, as the "billed charge" is almost never what is actually approved and (usually belatedly) paid. And I think there is a general mindset that medical practice is extremely lucrative, when nowadays there are a lot better paying jobs in the field, like hospital administrator.

And because of this decoupling, and the fact that an office based practice cannot economically take a half day or more to attend to hospitalized patients, has led to the development of hospitalists, and more recently "surgicalists", aka acute care surgeons. There are some positive things to say about this development, inasmuch as these subspecialties are in the hospital most of the time, probably are able to respond to in-hospital problems more promptly, and almost certainly shorten length of stay, which appeals to the people and institutions who pay the bills. The downside is that these personnel don't have a longitudinal relationship with the patient, even within the same hospitalization. (One of the founding principles of the American College of Surgery was its prohibition of "itinerant surgery", which today is pretty much a dead letter).

The other issue is the domination of practice by electronic medical records. For quite some time prior to the early "aughts", i.e. the first part of the present millenium, paper records were the norm. Lots of consultants, theorists, etc, wondered why this persisted since most other businesses and professions had converted to electronic records. And, in truth there are definite advantages to electronic records, probably most importantly the rapid input of imaging and lab reports (and the images themselves; I am old enough to recall when radiograms were actual prints on film negatives, that had to be checked out and returned, and got lost, misplaced, spoiled, etc, and there were no other copies. Access to electronic imaging is an important step forward, in particular now that a great deal of imaging is computerized in the first place.

The real impetus to electronic records, though, was the "Stimulus Bill" from the first Obama administration, where means to pump money into the economy to offset the negative effects of the "Bush Recession" of 2007-2008, which resulted from the sub-prime mortgage meltdown. The government was tasked with injecting money into the system to keep money flowing. Since it was generally accepted by those outside the medical care system that our records needed an upgrade, it was pretty much non-controversial to push some money in that direction. So, what initially seemed like generous support (which later, surprise surprise, turned out to be a lot less than would eventually be needed) was thrown in that direction, with a strong hint that not to adopt the new system was to be a troglodyte. Of course, with government money comes government regulation (except, curiously, the the Paycheck Protection Program (PPP), which had what are universally acknowledged now as inadequate oversight; but that is a different story for another time perhaps). Probably the most important of these was criteria for "Meaningful Use" of electronic records, so that shysters and grifters wouldn't just take the money and run. I don't think I was the first or only person to recast that phrase as "Meaningless Abuse", but I did at least come up with the phrase independently. This was a series of requirements for what must go into the record to qualify it as legitimate. Therein lies the rub. From progress notes to histories and physical exams, to procedure and operative reports, there is so much spam in those reports that finding the meaningful, actually useful input is like sifting through sand at the beach to find lost coins. Back in those good old days, we were taught that an operative report, for instance, should enable the person who later would read the report feel as if he or she were actually in the room, seeing and understanding exactly what was done, and what the reasoning behind it was. Nowadays, most of these reports are done with "templates", that satisfy no one but the bean counters and overseers, who won't read it anyway and who could care less. Trying to extract any information from some of these reports is a futile exercise. And that hurts, rather than supports, actually patient care. In fact, dealing with these dysfunctional records is a leading cause of what is being couched as "burnout". I think that is inappropriate; what physicians, as well as patients, want is a meaningful exchange of information, and a humanistic relationship so that the physician receives some sort of feedback that a benefit is being generated by his or her input.The system is such a drag, that being a glorified data entry clerk is not what we signed up for when we chose our profession.

I wish I had an answer to these concerns, but unfortunately I don't.

"Oh, the Good Old Days are dead and gone. A lot of good people have done gone on. That's my life a-when I sing this song about Back in the Good Old Days".

"Wrap-Up", Continued From Pg 11

MICRA

When the year began, the expectation was that CMA's focus in 2022 would be working to defeat the socalled "Fairness for Injured Patients Act" (FIPA) ballot initiative that had qualified for the November 2022 ballot. The ballot initiative, if it had passed, would have eviscerated the protections of California's Medical Injury Compensation Reform Act (MICRA). After Californians Allied for Patient Protection (CAPP), led by CMA CEO Dustin Corcoran, negotiated a legislative deal with FIPA proponents, Assemblymember Eloise Gómez Reyes put that legislative deal into AB 35, the MICRA Modernization Act. Just 16 days later, Governor Newsom signed the bill into law and FIPA proponents removed their initiative from the ballot. This historic agreement prevented a costly ballot fight and ushered in a new and sustained era of stability around malpractice liability.

MEDICAL BOARD

CMA aggressively fought AB 2060 (Quirk), which would have created a pub-

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