North Coast Physician

In This Issue:

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The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication.

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E-Mail: hdncms@sbcglobal.net Web page: *www.hdncms.org*

The "Filled But Not Fulfilled" Syndrome

Scott Sattler, M.D.

Soon after starting my outpatient and ER practice on the Hoopa Indian Reservation in 1974, it became clear to me that my fundamental concept of what it took to work as a rural primary care physician was significantly flawed. I had just completed medical school at Stanford and internship at Santa Clara Valley Medical Center in San Jose when I set out into the world quite naively under the assumption that I had acquired the skills needed to ply my trade well. At that time my vision of a competent remote rural physician was one who could handle any acute problem that came through the door of the office or the ER. The patient would be treated definitively or else be stabilized and transported to the nearest appropriate facility. It didn't take long to realize that on many levels my capacity to be such a primary healthcare provider was inadequate.

My first somewhat stunning revelation was that only about half of the patients I saw had problems based primarily on the physical plane. These were mostly the trauma patients and those with acute infectious or metabolic disorders. I had been well trained to diagnose and treat folks with these "dis-eases" and doing so fit the role I had envisioned.

The problem was that fully half of the remaining patients suffered from significant health issues that were rooted in the mental/emotional plane. This was true for both office and ER patients. Eventually I came to understand that in order to survive as children in dysfunctional families, many people acquire behavioral patterns that are strikingly dysfunctional as adults. Their subsequent social dysfunction often wreaks havoc in their lives. While I could help repair their physical bodies, I found that I had very little to offer with respect to amelioration of their primary mental/emotional dysfunction. My medical training had been heavily weighted toward the practice of physical medicine. Behavioral therapists were hard to find in this remote region, and often patients did not wish such referrals because of the associated social stigma. Thus transfer to more definitive care was rarely accomplished and then only in the most dire cases.

In 1982, I moved to Eureka and joined a busy family practice. As time passed, I grew to recognize yet a third category of dis-ease that significantly impacted personal health. The onset of this disease was subtle. From my experience it occurred largely but not exclusively in the middle and upper economic classes. Its time of onset ranged from early adolescence to late adulthood and it occurred in both sexes. I have come to call this condition the "Filled-but-not-Fulfilled Syndrome." It has at least two separate presentations. The most common

Opinion, Continued on Page 20

Passing of the Gavel

Mark Ellis, M.D., Outgoing President (L) and Sandra Wilcox, M.D., Incoming President (R)

Productivity: the Industrialization of Medicine

STEPHEN KAMELGARN, M.D.

Just in case you've missed it, there seems to be a movement afoot to standardize, and ultimately industrialize, medical practice. As electronic medical records makes larger and larger inroads into our lives, this process becomes easier to institute and shove down our throats. EMR, with its pre-fab templates, constant reminders and biller friendly formats forces us into a mode of practice where we, as healthcare providers, are being downgraded to glorified cogs in an increasingly monolithic machine. The software engineers make the calls, not the physicians.

The latest buzzword that alludes to this change is "productivity." Everybody from Kaiser to Medicare wants us to improve our "productivity." The cover story in Medical Economics a couple of months ago was: "How to improve your productivity." It's everywhere. When I see all this stuff, I get the feeling that when my "productivity" is maximized I will have entered into a Golden Age, where all's right with the world, the sky's always blue and world peace will have been achieved. NOT.

I've looked up this nefarious word, and, according to The American Heritage Dictionary (3rd edition, 1996) productivity is defined: "economics The rate at which goods or services are produced especially output per unit of labor." Since when do we produce "goods" (i.e. make stuff for sale). And, although we do perform services for our patients, I don't see us as "service providers," an important sector of the economy to be sure, but it's not our role. Medicine is not a commercial enterprise. There are so many ways in which it differs from commercialism. It therefore, doesn't lend itself to the standardized protocols that our industrial and post-industrial society demand.

Increasing services per unit of labor demands standardization and standardized protocols. And medicine can only be standardized so far. Ultimately, the interaction between physician and patient is an individualized, one-on-one, interchange; impossible to pigeon hole and standardize. To give good medical care one must really see the patient, and, if possible, lay hands upon him or her. One must not stand behind the counter as though selling tickets at a shooting gallery.

If I remember my medical school education correctly, we take care of patients (not nameless things), and provide them with the means to improve their health. We don't stand next to a cash register and add up all the goodies they buy from us. We're not on an assembly line somewhere putting the fenders on cars as they roll down the line. Health care is a need, not a want. Continuing to promote the idea that healthcare is a "product" is ludicrous.

While productivity may have some usefulness in describing industrial output or comparing wages among workers in different industries, it should have no place whatsoever when describing the delivery of medical care. Whether we like it or not, whether the government bean counters and insurance executives like it or not, we are not engaged in making consumer goods or any other similar activity. We are actually more like a crafts guild that relies on a combination of science and artistry to deliver care to human beings. Individual human beings do not fit into an industrial model, and while people may be treated statistically when predicting election outcomes or the popularity of TV shows, individuals must be given time to explain themselves and develop relationships with their physician.

Medicine is probably the last profession where we can all remain "artisans." Over the years manufacturing has moved from customized, individualized crafts to assembly line standardized products and procedures. We no longer hand make cars or anything else. These items now roll off the assembly lines in their identical thousands. While this may be very good for providing inexpensive consumer products, it doesn't speak well for medical care. Office workers are now gauged by how many "productive keystrokes" they hit on their computers while at work. Is this how we wish to be gauged?

In medicine, each patient is an individual that requires individual, "customized" care. This holds true whether we're treating a strep throat, or trying to convince someone why it's important that they take their blood pressure pills regularly. While EMR is very good at reminding us of the health maintenance stuff we all must do (especially if we expect to get paid under P4P): colonoscopy at age 50, mammograms, flu shots, etc. there seems to be little evidence that performing most of this stuff actually improves health outcomes. And while we may be expected to practice evidence based medicine, it still takes time to convey those evidences to patients and work with them to improve their overall health. We also know that when patients try to follow sound medical advice and work on their own to maximize their health they do tend to feel better–although this is an outcome that can't be quantified. And when we deliver this ad-

Thoughts, Continued on Page 21

2013 AABB Audioconference Series

MARGARET GORDON, M.D.

Medical Director, Northern California Community Blood Bank

Please see below for the Audioconference schedule for FEBRUARY - APRIL 2013

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4/24/13	**"Protocols for Supporting HPC Transplant Patients Prior to, During & After HPC Transplants"**

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Opinion, Continued From Pg 5

in my experience, its covert stage, is that of a patient exhibiting a deep, prolonged ennui, often manifesting during times of inactivity. It carries with it a nagging, tedious and vexing sense of existential stagnation. It is as if something profoundly important is missing in the patient's life and they just can't put their finger on it. It is characteristically recurrent, annoying, and impossible to ignore for any length of time. Oddly, fleeting contemplation of this state often induces yet more discomfort. The symptoms do not meet the criteria for the diagnosis of a depressive disorder.

The second presentation of this condition, its overt stage, sometimes brings the patient to the attention of a physician, for in an attempt to satisfy this inner sense of 'something missing', the patient often dedicates a great deal of time and energy sequentially pursuing a host of goal-directed activities. These activities tend to be more balanced and rational than those found in mania and hypomania. They may involve taking on a series of non-fulfilling hobbies that consume an inordinate amount of time. They may take the form of engaging in pursuing a myriad of social or political activities. Yet other patients seek resolution through an increase in material consumption, hoping to find happiness and fulfillment through this process, just as the media suggests. Some turn to alcohol or stimulants, some to gambling, some to other potentially self-destructive paths for various periods of time. The outcome for most is yet more inner dissatisfaction. Few if any with this syndrome find resolution of their condition on the path of addiction, unless it is through a recovery process. Those who choose hyper-consumption tend to discover that insatiability is not only unsustainable but that it, too, is ultimately unsatisfying. Those who elect to saturate their lives with busy-ness tend to find that the process of converting from a human being to a 'human doing' does not provide the solution they are seeking.

The common denominator of this syndrome lies in the often-unacknowledged, subtly compulsive effort of the afflicted to fill their lives with something that provides a prolonged, reliable sense of fulfillment. The Filled-but-not-Fulfilled Syndrome does not reflect physical disease. I also do not feel it to be a mental/emotional disease state, for in my experience it transcends the thought processes and is essentially existential in nature. Over time I have come to consider that this condition reflects an imbalance within yet a third major aspect of our being. For the sake of this discussion I'll call it the "spiritual" aspect, for it primarily affects the human spirit, as in "I am in good or bad spirits today." It is not necessarily associated with religiosity. I think that this third aspect deals with that part of our being that Robert Frost described in his poem "The Secret Sits", in which he wrote:

"We dance round in a ring and suppose,
But the secret sits in the middle and knows."

It is my perception that there is a deep interiority within the human being and that one property of this interiority is its innate manifestation of existential guidance. Many, if not all, intermittently touch upon it as they pass through life. My sense is that individuals choose whether or not to establish a relationship with this part of themselves. It is also my sense is that those who do nourish this relationship have a much lower incidence of the syndrome discussed above.

In summary, I have come to think that for most people true health requires balanced attunement to the physical, mental/emotional and spiritual aspects of their beings. Lack of attention to any of these elements induces an imbalance that powerfully affects the health of the whole. §

Thoughts, Continued From Pg 6

vice we cannot force it into a cookie-cutter mold, if we expect to make headway with our therapies.

As much as the bureaucrats may try, you can't pigeonhole a medical visit into a precut template. Although we may be jammed into a seven minute appointment there is both a qualitative and quantitative difference in using that seven minutes to treat a 16 year old with a cold and a 76 year old with end-stage heart disease. If we take the time that we actually need, our "productivity" goes down, although we may actually do a better job, and have higher job satisfaction. If we do what the bureaucrats and insurance people ask, and see four patients an hour, then our "productivity" can be measured, although the intangibles of both patient and physician satisfaction and the very nature of our vocations is consigned to the rubbish heap.

I know that health policy economists have devised a bunch of formulas that are supposed to state with amazing exactitude how many people we should be seeing based on our "patient mix." However, none of these "experts" actually sit in a room with a patient and try to tease out the elusive and unique aspects of the office visit. Even for two patients with identical conditions the visits cannot be standardized. One patient may be in total denial of the condition while the other wants to know everything he/she can do to make themselves better. The visit is dependent on our patients' level of education, level of motivation, complexity of health conditions and the patients' social milieu. I ask you, "How can this be standardized and measured as 'productivity'?"

Certainly, much of what we do is quantifiable: How long it takes to do a hip replacement; how many colonoscopies one does in a day, how quickly dictations are completed, etc. But when a physician is counseling, teaching or otherwise engaging intellectually and/or emotionally with a patient then all bets are off. That part of the medical visit cannot be measured, parsed or otherwise subjected to quantitative analysis. If we can't quantify the process, then how can we effectively standardize that process?

There always exists a dynamic, dialectic tension between having to see a large volume of patients and devoting the appropriate amount of time to each patient so that we may maximize their health care. A ten minute visit may be fine for some people, while others may require 45 minutes or longer. How each of us individually balances that dialectic is what ultimately defines our practice. We should not be using the economic concept of "productivity" to resolve this dialectical dynamic. For this concept reduces people to widgets and physicians to nothing more than widget makers. §

Del Norte, Continued From Pg 9

Sutter Coast Hospital?

Based on hospital patient census figures since 10/1/12, if Sutter Coast had been a Critical Access facility, at least 86 patients would have been transferred to outside hospitals. The hospital would have been closed to new admissions 50% of the days. Yesterday, there were 34 patients in the hospital. Under Critical Access, yesterday alone, between 9 and 12 of those patients would have been flown to an outside hospital.

Meanwhile, Asante Health System, owners of both Three Rivers Hospital in Grants Pass and Rogue Regional Medical Medical Center in Medford, are standing by to assist us in the event Sutter leaves.

How Can We Stop Sutter?

Most of all, we speak up! Together, we can stop Sutter and create a better hospital for our two counties.

Call or email our representatives often! They want to hear from us. Tell them what you think of Sutter Heallth's attempt to end 28 years of local ownership and governance of Sutter Coast Hospital, even though every elected official in Del Norte County opposes Sutter's plans. Ask them to support our Healthcare District's legal action against Sutter--the Healthcare District alone cannot match Sutter Health's legal might. Tell them we need a hospital management firm that is honest, listens to the community, and will not cut our hospital in half.

Write a brief letter to the Triplicate, with a cc to the Board of Supervisors. The Triplicate provides our community a great forum to express concerns and exchange ideas. If you have a question or comment to share, send me an email at drgjduncan@yahoo.com

Write the County Board of Supervisors, who this week heard concerns from Dr. Kevin Caldwell and me, available here: http://www.ustream.tv/recorded/28725986

The presentation begins 45 minutes into the meeting. The Supervisors were unanimously supportive of our efforts.

Thank City Council members Kelly Schellong and Kathryn Murray, and Supervisor Martha McClure, all of whom serve on the Healthcare District subcommittee opposing Sutter, for their efforts.

Many thanks to those of you who have written letters, stopped by my office to sign the petition, and given Anne Marie and me encouragement. Your support is more important than you know.

Read more about this issue on our website at http://crescentcityhospital.blogspot.com/

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