North Coast Physician
May 2009

Death may be inevitable, but so what else is new?

Stephen Kamelgarn, M.D.

Elsewhere in this issue we have a guest article from Dr David Goldschmid of the San Mateo County Medical Association. In this article he equates physician shortage with lack of access to care. He then goes on to explain the forces at work that contribute to the loss of access.

While I don't dispute that it really is lack of access to care that is the true problem, I do take issue with some of the explanations that he gives for this "crisis." First off, he mentions my favorite bugaboo word of all time: *productivity*.

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 widgets 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. 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. Therefore, we shouldn't be "shoe-horning" patients into the traditional 15 minute visit. 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. 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 patient and physician satisfaction and the very nature of our vocations is consigned to the rubbish heap.

Many physicians are working fewer hours than our counterparts of 25-30 years ago. As Dr Goldschmid mentions there are a variety of reasons for this, but he gives the impression that we've lost some mythical "golden age" when "men were men and we were available at all

times.” What he doesn’t mention is the price we paid back in the “good old days.” Physicians had some of the highest divorce rates, suicide rates and addictive behavior rates of any profession in those days. We missed seeing our children grow up, and many of us were virtual strangers in our own homes. Also, technology has advanced spectacularly in both the outpatient and inpatient settings demanding that we remain sharp at all times; it is impossible to get away with being half-asleep in either the office or the hospital. This is one of the reasons we’ve seen the rise of hospitalist physicians. The skill-sets required for outpatient doctors and hospitalists are beginning to diverge dramatically, and now it is very difficult, if not impossible, to do both jobs well.

As Dr Goldschmid points out there are huge economic dis-incentives for people to go into medicine, primary care in particular:

> “Society has effectively shut off the supply of Primary Care Physicians by refusing to pay for cognitive care. Less than 2% [actually it’s more like 7% of MD grads, but 40% of DO grads, see “The 7% (non)Solution” *The Bulletin,* March, 2009–ed.]of medical students plan a career in primary care. We have always been willing to pay for procedures, but have decided that now all we really value are very exotic procedures and technologies. Thus we have started to shut off the supply of General Surgeons by not paying them as well. The virtual elimination of these two specialties will cripple access to care
>
> “I believe that what we are witnessing here are multiple forces, working independently, determined to reduce costs by eliminating our desire to practice while at the same time professing to care about access, but knowing reducing access must happen. The hostile governmental environment and over-regulation physicians have experienced are designed to make reimbursement difficult and low, and to make medical practice undesirable. These forces result in reducing the number of practicing physicians or at least their productivity, to reduce access to reduce costs. Over regulation, bad press against physicians, lowering reimbursement, proliferating HMO principles where profit is tied to reduced productivity, trying to punish us for virtually anything that can go wrong, artificial constraints on marketplace forces such as constraints on balance billing, and Orwellian systems set up to pay us for doing our jobs well instead of simple systems, are not accidents. The intent is to reduce access and it is working.”

For any meaningful health care reform to take place in the US it must be primary care driven, as it is in every other system that “works.” Until we can remove the roadblocks to reimbursement and payment then there will always remain a broken, tottering system with no-one going into medicine, just as we aging baby boomers will require more care and services.

It is Dr Goldschmid’s last paragraph that I have the most trouble with. He states: “When society finally understands that death is inevitable and that lawyers cannot manage medical care,

we will be able to devise rational cost containment. Then government will act to make the physician shortage improve." This seems to imply that, in order, for health care reform to happen, we must all lower our expectations, since having high expectations is expensive. He seems to equate our high cost of health care with our desire to live forever. Now, while no society can afford to give every single one of its citizens total, unrestrained access to all health care resources, that doesn't necessarily mean that we must lower our expectations of what we expect from the healthcare system. Yes, death is inevitable, but we aren't here to make people immortal, we are here to help improve the quality of peoples' lives to whatever extent possible during whatever life-span they may have.

Medical care in the United States is too expensive, but "recognizing our mortality" is not the first step in reining in costs. We must realize that the laissez-faire system we have, controlled by insurance interests, driven by Big Pharma and advertising, and fragmented into a million different plans, each with its own overhead costs is what has our costs so out of line with the rest of the world. As I mentioned in my editorial in February ("Health Insurance: an Oxymoron," *The Bulletin* Feb, 2009), if we adopt a Medicare for all plan coupled with some sensible cost cutting measures we can save the economy more than *one trillion dollars* over the next ten years. Now *that's* cutting costs, but not cutting services.

Will Medicare for all improve access to care? Only if in that reform there are incentives for people to stay in this profession–both financial and emotional, for as Dr Goldschmid so rightly points out, if people don't go into medicine there will be no doctors to deliver any care.

May 2009