The Ten Questions Walter Cronkite Would Have Asked About Health Care Reform

An electronic book free of charge

Also Included:

Road Map to Affordable Coverage
Essays from my blog
The Voice of Physicians – Results from a National Survey

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“America's health care system is neither healthy, caring, nor a system”

-Walter Cronkite

This electronic book is dedicated to the people of the United States who deserve careful, well thought out proposals and solutions devoid of political rhetoric in an attempt to solve one of the major problems of our time, health care.

Table of Contents

Introduction **4**

Section 1 - The Ten Questions **6**

Overview of the Ten Questions 7

Answer to question 1 9

Answer to question 2 12

Answer to question 3 17

Answer to question 4 20

Answer to question 5 23

Answer to question 6 26

Answer to question 7 29

Answer to question 8 31

Answer to question 9 33

Answer to question 10 35

Section 2 - Road Map to Affordable Coverage **41**

Introduction 42

Major Flaws in our Health Care System 42

Recommendation 1: Specific Actions by Congress 44

Recommendation 2: A New Style of Hospital Admission Form 47

Recommendation 3: Expanded Peer Review Committees 48

Summary 50

New Hospital Admission Form 51

Section 3 - Essays from My Blog **52**

Part A – Problems with Today's System 53

Part B – Faults in the Present Solutions to Health Care Reform 72

Part C – How to Fix Our Health Care System 99

Section 4 - The Voice of Physicians– Results from a National Survey **130**

Introduction 131

Highlights from the National Survey 132

The Survey 134

Introduction

Here is the information you need to be able to ask the fundamentally important questions about health care in America. There is no doubt that this issue is still a major topic for our society and everyone should be equipped to be able to ask difficult and illuminating questions. Why is it so expensive, why are outcomes poor when compared to other Western nations, why is the public so angry, why if we already spend so much do we have to spend more to provide universal coverage when other countries do so at far less cost? Is there a way to cover all Americans and yet decrease not increase Federal and State spending? What has happened to the healing patient-doctor relationship, why is American medicine so drug, device and test intensive?

Healthcare today consumes about 17% of gross domestic product (GDP), approximately $7,600/person, almost twice as much as any other country, and is a major contributor causing manufacturing to leave this country along with good paying jobs. States, partly because of Medicaid spending, are not adequately funding public education; thus many youngsters are not prepared to participate in a world-wide competitive economy which then leads to increased poverty. Despite spending this large fraction of our GDP on health care, we have approximately forty-five million uninsured individuals. The present attempts to provide universal coverage is calculated to consume 20-22% of GDP, which will worsen our manufacturing competitiveness and utilize taxes that could be spent on decreasing our deficit.

The good news is that by two completely different methods it has been shown that about one third ($700-800 billion) of our health care spending is of no benefit. The object of a thoughtful plan should be to understand the reasons why this very expensive non-beneficial care is taking place and how to address and rectify these factors. Not only would care improve, but there would be enough savings to provide universal coverage while spending less.

Unfortunately the recently passed Patient Protection and Affordable Care Act although providing for almost universal coverage does so by proposed large decreases in Medicare funding causing many or perhaps most hospitals to face financial ruin. The Act relies heavily on significant increases in Medicaid spending that will eventually put a greater burden on state budgets, decreasing their ability to fund public education, just the opposite of what is in our society's best interest.

This law is primarily an insurance bill and does not examine the various forces acting on the patient-doctor relationship that have led to where we are today.

This electronic book will provide the information you need to better understand these forces and give you solutions that would allow us to have universal coverage at a lower not greater cost. You would then be better able to address this issue when questioning policy makers and "experts". Future essays along with questions or comments about this material may be posted on my blog, http://drkennethfisher.blogspot.com ; I will do my best to address them in a timely manner.

Section 1 – The Ten Questions

I initially wrote these ten questions and the answers for my blog, which I own and is original with me and from which they have been copied and pasted. I believe you will find the questions and answers helpful as you try to understand the vast complexities of our health care system.

Overview of the Ten Questions

I often yearn for the days when we had news people like Walter Cronkite, Peter Jennings, the tenacious reporters from the New York Times and others who could truly think and had a keen eye for the issues at hand. They did their homework and, when conducting interviews or participating in Capitol Hill news conferences, asked pertinent, meaningful questions even if it made the person being questioned squirm. They examined all sides of an issue – good, bad, and everything in between – to bring balanced reporting to important national debates – balance that is decidedly missing now.

Congress has enacted a health care plan that simply won't work and will cost taxpayers a small fortune for generations to come. And, so far, no one in the media - either broadcast or print - has asked any of the questions that really need to be answered and addressed in order to bring reform that will work and won't break the bank.

Here are the questions I feel needed to be asked by the national media, and should have been asked as this process was getting underway. Possible answers will follow each question on succeeding pages.

1. What is medical consumerism and what factors do you believe exacerbate this issue? Are you familiar with Professor George Annas's article on the Baby K case in the May 26, 1994 pages 1542-1545 issue of the New England Journal of Medicine regarding the impact it is having on medical care in this country? How do you think we should address this problem?

2. Various experts using different methods have determined that Americans presently spend about $700 billion a year on inappropriate non-beneficial care and that this excess spending is primarily due to physician practices. What do you believe are the factors causing physicians to practice this way and how would you address these issues?

3. The business round table has stated that our present high health care costs as reflected by the percentage of gross domestic product (17%), that is much higher than other countries, is driving manufacturing and its high paying jobs out of this country. How should we address this issue?

4. Why does the cost of care in teaching hospitals vary so dramatically from hospital to hospital, as documented by the Dartmouth Atlas of Health Care, despite the fact that their physicians are salaried and do not charge fee for service?

5. Why do we have so many sub-specialists and so few primary care doctors despite the fact that primary care doctors are the key to providing coordinated care of high quality for less cost? How can we can we remedy this imbalance in the near future?

6. What has been the history of decreases in Medicare payments? Have they been successful and what effect do you believe these policies have had on American medicine?

7. What is the effect on working Americans of private insurance having to subsidize Medicare and Medicaid?

8. What do you think is the effect on state budgets of having to assume about 50% of the costs of Medicaid?

9. When can a patient reasonably utilize choice in care and in what situations are choices reasonably limited and who should determine when those conditions are reached?

10. What do you think is the result of cobbling together various constituencies in trying to pass a health care reform bill?

Answer to Question # 1

What is medical consumerism and what factors do you believe exacerbate this issue? Are you familiar with Professor George Annas's article on the Baby K case in the May 26, 1994 (pages 1542-1545) issue of the New England Journal of Medicine regarding the impact it is having on medical care in this country? How do you think we should address this problem?

A) The concept of patient autonomy is problematical as its limits have not been defined.

B) Many Americans believe that a few hours at a web site is sufficient to adequately learn about a medical subject without understanding the complexities involved.

C) Drug and device advertising to the public promotes the newest most expensive drug/device as superior and your doctor is unaware of this marvelous advance. In reality direct advertising is an attempt by these companies to convince the public that their product is the newest and best when usually older and cheaper drugs/devices are just as effective[1].

D) Hospitals and doctors have adopted a customer oriented business model to maximize revenue.

E) There are unresolved ambiguities caused by the Patient Self Determination Act (1990) which created the legal framework for advanced directives.[2] Many ethicists and physicians have noted that advanced directives have the potential of turning the physician into a technician following instructions no matter how inappropriate.[3] Questions arise about the limits of therapy in the absence of an advanced directive. Although passed in 1990, these concerns are yet to be addressed by Congress.

F) Physicians practice defensive medicine because of the widespread fear of lawsuits. Our legal history is replete with cases that have demonstrated to

the physician community that logic and rationality are secondary to patients'/families' requests and desires.

Two examples of this are the cases of Baby K and Helga Wanglie.

1) In the Baby K case an anencephalic baby (no cerebral cortex – no possibility for consciousness or human activity) was born by caesarian section in 1992. Although the physicians, hospital ethics committee, the court appointed guardian and the child's father recognized the futility of further care, the child's mother insisted on continuing care along with mechanical ventilation (breathing tube connected to a machine) if needed and pursued legal action. The trial court misinterpreted the Emergency Medical Treatment and Active Labor Act (EMTLA)[4] by not considering the child as an integrated entity, but rather as a respiratory case. Professor Annas, Chair Department of Health Law, Bioethics & Human Rights at Boston University made several cogent statements about this case: 1) Knowing in advance that the fetus was anencephalic ,before delivery the physicians should have discussed with the mother that they would not use mechanical ventilation after birth. 2) The trial judge misinterpreted the intent of Congress in writing the law. 3) Congress mistakenly did not include wording such as, "within the bounds of good medical practice". 4) We should be treating patients in light of what is best for them and not as objects to meet the needs of others. 5) To avoid medicine becoming a consumer product like toothpaste and in the process becoming unsustainably expensive, physicians will have to set standards for medical practice and follow them;[5] to this date this has not happened

2) In the Helga Wanglie case, an 86 y/o women was in a persistent vegetative state for a year in an intensive care unit. The physicians concluded that in this case there was no chance of recovery and that hospice would be better for the patient. Her husband objected and sought relief from the courts, which found in favor of the husband; however, Helga died a few days after the verdict.[6]

What is needed to address medical consumerism and resolve the ambiguities between patient and doctor? I suggest:

1. Congress should amend the Patient Self Determination Act, The Americans with Disabilities Act and the EMTLA to contain the phrase, “within the bounds of good medical practice”. This would facilitate physicians developing and adhering to practice standards.

2. An advance directive should be completed at each hospital admission with guidance from physicians as to what is feasible in light of the patients overall condition, with seasoned physicians and a nurse available to adjudicate conflicts.

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[1]Angell M. The Truth About the Drug Companies: How They Deceive Us and What to Do About It. Random House N.Y. N.Y. 2004 ISBN: 978-0-375-50846-2

[2]The **Patient Self**-**Determination Act** (PSDA) was passed by the U.S. Congress in 1990 as an amendment to the Omnibus Budget Reconciliation Act of 1990.

[3]Perkins HS. Controlling death: the false promise of advance directives. *Annals of Internal Medicine* 2007; 147: 51-57 (PMID 17606961)

[4]42 U.S.C. 1395 dd (1994) (amended 1997)

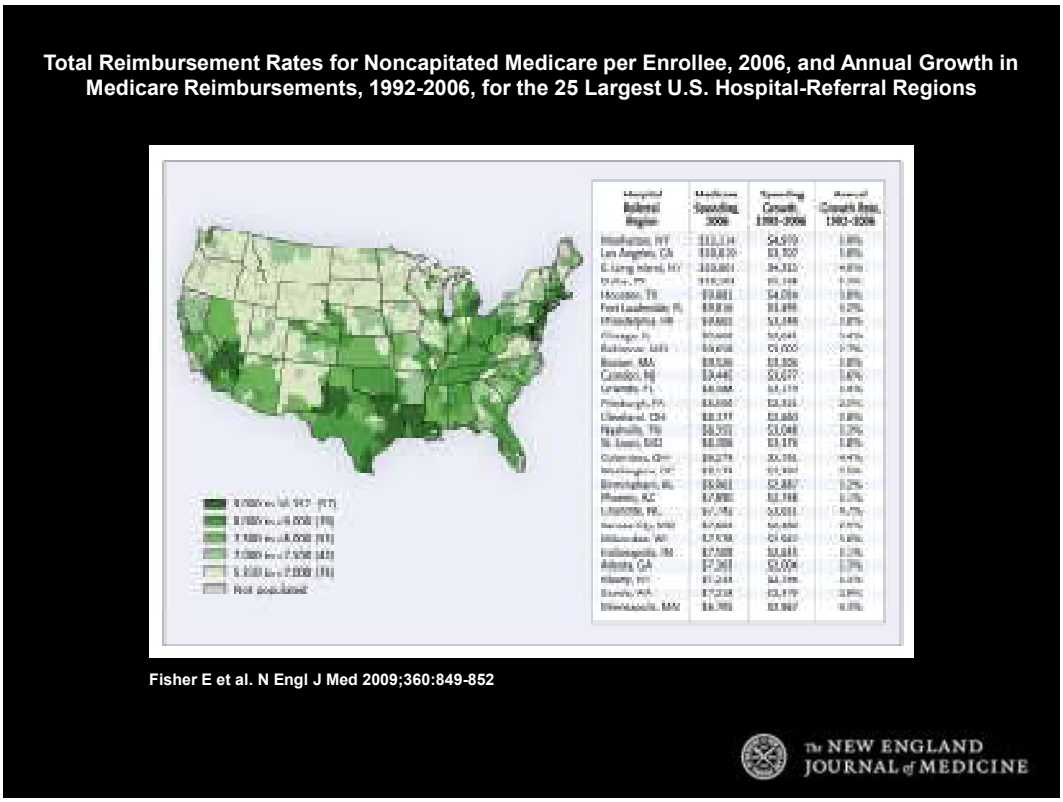
[5]Annas GJ. Asking the courts to settle standard of emergency care – the case of Baby K. *New England Journal of Medicine* 1994; 330: 1542-1545 (PMID 8164726)

[6]Angell M. The case of Helga Wanglie; a new kind of “right to die” case. *New England Journal of Medicine* 1991; 325: 511-512 (PMID 1852185)

Answer to Question # 2

Various experts using different methods have determined that we Americans presently spend about $700 billion on inappropriate non-beneficial care and that this excess spending is primarily due to physician practices. What do you believe are the factors causing physicians to practice this way and how would you address these issues?

A) There are multiple studies and estimates by experts leading to the conclusion that about $700 billion dollars per year are spent on unnecessary, inappropriate care in the United States.



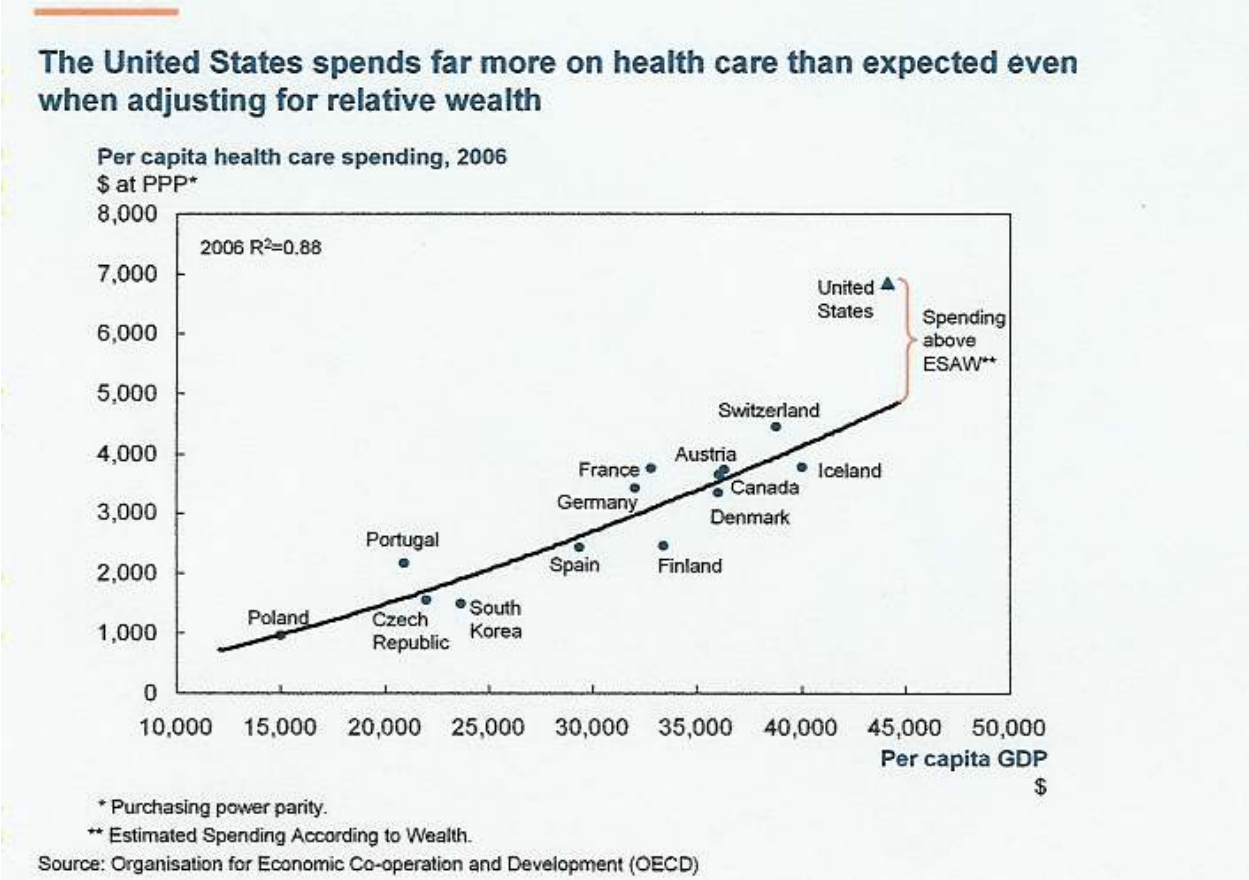
Peter Orzag (formerly head of the Congressional Budget Office, and Director of The Office of Management and Budget) using this data is quoted by Trapp D., "…estimated that up to $700 billion of the nation's $2.3 trillion in annual health care spending does not improve outcomes". [1]

1) The Dartmouth Atlas of Health Care

Kenneth I. Shine , former President of the Institute of Medicine of The National Academies of Science in an editorial responded to an earlier version of this map saying, "….as much as 30% of health care costs might be eliminated without adversely affecting health care outcomes."[2]

Arthur Garson and Carolyn L. Engelhard said in their book, "We do waste a lot of dollars on medical care, but this "one-half" estimate is based on an over-zealous interpretation of the data: the number is more likely one-third."[3] This one-third estimate exceeds $700 billion per year.

2) McKinsey & Co. December 2008 demonstrated by a different method that compared to other countries the U.S. wastes about $700 billion yearly on health care.



B) Dr. Arnold S. Relman former editor of the New England Journal of Medicine wrote, “Doctors, in consultation with their patients — not insurance companies, legislators, or government officials — make most of the decisions to use medical resources, thereby determining what the United States spends on medical care.”[4]

C) There are several factors causing physicians to practice in this way.

1. Doctors feel compelled to practice defensive medicine – the Massachusetts Medical Society has studied the cost of the yearly amount (2008) spent on defensive medicine in an attempt to minimize lawsuits. The study revealed that in Massachusetts a conservative estimate was $1.4 billion.[5]

2. Unrealistic demands by physicians placed on patients/families, in the name of patient autonomy, to make sophisticated and frequently non-beneficial and expensive medical decisions. These practices are well described by Dr. Atul Gawande in his book Complications.[6]

3. The present structure of advanced directives causes confusion and unrealistic expectations.[7]

4. Congress’s control of Medicare reimbursement rates under the influence of intense lobbying has resulted in the underfunding of primary care and overspending on technology and drugs.

5. Drug and device companies are now allowed to advertise to the public.

D) To address these problems I suggest the following actions:

1. Congress should amend The Patient Self Determination Act and related acts to contain the phrase, “within the bounds of good medical practice”.

2. Congress stipulates the use of a hospital admission form (below) for all Medicare patients. This form would enable patients to clarify their medical preferences with guidance as to medical feasibility along with an appeal mechanism in case of conflict.

3. The scope of peer review expanded to include consistent, uniform, organized oversight by senior physicians and nurses with knowledge

and experience in the practice of medicine and patient/family support to ensure that only beneficial care was being delivered.

4. Internal medicine sub-specialists should provide primary care for their patients who do not have a primary care physician.

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[1]Trapp D. Obama budget sets stage for reform of Health care system, Medicare pay, American Medical News. March 16, 2009 page 4

[2]Shine KI. Annals of Internal Medicine. 2003; 138:347-8. PMID: 12585834

[3]Garson A, Engelhard CL. *Health Care Half Truths: Too many myths, not enough reality.* N.Y., N.Y. Rowman & Littlefield Publishers, 2007, Page 17

[4]Relman AS. Doctors as the key to health care reform. New England Journal of Medicine 2009:361: 1225-1227 PMID 19776404

[5] www.massmed.org/defensivemedicine (accessed April 20, 2010)

[6]Gawande A. Complications: A surgeon's notes on an imperfect science. N.Y., N.Y. Henry Holt & Company, 2002, Page 208

[7]Fisher KA, Rockwell LE, Scott M. In Defiance of Death: Exposing the Real Costs of End-of-Life Care. Westport, Connecticut , Praeger 2008, Page 11

New Hospital Admission Form

Appropriate Care Hospital Admission Form

Name _____ Med. Record #_____
D.O.B. _____ Date _____

1. Is Patient capable of decision making: Yes ( ) No ( )
   If No, who is responsible? Next of Kin/ guardian: _____
   phone_____

2. Cardiopulmonary Resuscitation (CPR) is ordered on this patient: Yes ( ) No ( )

   Place the following restrictions on CPR. DO NOT DO THE FOLLOWING:
   ( ) intubation ( ) chest compression ( ) resuscitation drugs ( ) cardioversion

3. When thought to be in an end of life situation by the medical team, I want to receive palliative care and consider placement in hospice: Yes ( ) No ( )
   If No, the appropriate care I want is: _____

4. Other therapies this patient has chosen to refuse even though medically indicated are:

5. Other Stipulations or Concerns:

This form serves as a guide for physicians to carry out the wishes of the patient. There is a hospital physician team responsible for oversight of appropriate care, whose goal is to help define beneficial care appropriate for the patient (the benefit to the patient significantly exceeds the risks). An expanded peer review care committee is available for the patient should conflict arise.

Physician Signature _____
Patient Signature _____
Witness Signature _____

Answer to Question # 3

1. **The business round table has stated that our present high health care costs as reflected by the percentage of gross domestic product (17%) that is much higher than other countries is pricing manufacturing and its high paying jobs out of this country. How should we address this issue?**

2. **During the recent health care debate one of the stated goals was that any health care bill should *not* increase the federal deficit. There was no discussion on the effect that the percentage of gross domestic product (GDP) devoted to health care has on the overall economy and jobs. There was also no discussion on how a negative effect on the economy would decrease tax revenue and thus have a profound effect on the federal deficit. According to this line of reasoning two issues arise regarding the *Patient Protection and Affordable Care Act,* (1) will there be a significant increase in the percentage of GDP devoted to health care and (2) if there is a significant increase of GDP devoted to health care would this cause a decrease in good paying American jobs?**

Answer to (1) The Chief Actuary of the Centers for Medicare and Medicaid Services, Mr. Rick Foster, has calculated that when this law is in full effect it will increase the percentage of GDP devoted to health care to 21% and that the cost containment efforts will be largely ineffectual. (http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf).

Answer to (2) In addition to the business roundtable assessment Cathy Arnst wrote in Bloomberg BusinessWeek July 23, 2010, "The rate of growth in U.S. health care costs has outpaced the growth rate in the gross domestic product (GDP) for many years. In 1940, the share of GDP accounted for by health care spending was just 4.5%. By 1990, it had reached 12.2%, and 16% in 2005, when health care spending totaled nearly $2 trillion, or $6,697 per person, far more than any other nation. This year health care spending is on track to equal 18% of GDP" and that a recent Rand study revealed that this imbalance (especially when % GDP devoted to health care reaches 20%) versus other countries does have a negative impact on our economy and jobs. This newer information coupled with

this statement from the Henry J Kaiser Foundation and the Health Research and Education trust, “Health care costs skyrocket in United States, threatening to bankrupt national economy”, adds credence to the concept that no matter how we pay for health care, our excessive costs must be successfully addressed for us to pass prosperity on to our children. Not only will these excessive relative health care costs cause jobs to *decrease* , but by hampering economic activity it will also decrease federal tax revenues adding complexity to an already difficult problem.

How would a rational society deal with the problem of meeting its need for universal coverage while at the same time get its percentage of GDP devoted to health care more in line with other countries?

1. Deal with the pivotal meaning of Dr. Relman’s statement, “Doctors, in consultation with their patients- not insurance companies, legislators, or government officials – make most of the decisions to use medical resources, thereby determining what the United States spends on health care”. (New England Journal of Medicine September 24, 2009).
2. Understand the forces (i.e., perverse payment system encouraging an overly technological style of medicine, unrealistic public expectations, adverse legal environment, excessive administrative costs and complexity) acting on the doctor-patient relationship that are causing American medicine to be so expensive.
3. Understand the changes that will be necessary to rectify these pernicious factors. Although the new health care bill makes attempts to control costs, most experts suggest that these attempts will be marginal at best. Seriously addressing the changes needed to bring our health care costs more in line with other nations will cause many powerful entities, (i.e. pharmaceutical and devise companies, intensive care units, some specialists) to have a decrease in income thus requiring greater political will to bring about real cost containment.
4. Adopt a process of doctor-patient agreement on the primacy of beneficial care and physician oversight to insure the practice of evidence-based national standards along with the creation of a health care agency that would be independent of lobbying activity. This agency would create national insurance options, a national electronic medical record, a rational physician payment schedule and many other administrative functions.

There is no doubt that the physicians in this country, if given the right tools, can provide universal coverage costing no more than 15% of GDP.

Answer to Question # 4

Why do teaching hospital costs vary to the degree that they do, as documented by the Dartmouth Atlas of Health Care, despite the fact that their physicians are salaried and do not charge fee for service?

Using the Dartmouth Atlas of Health Care data an article in Time magazine (June 29, 2009) by Michael Grunwald compares the costs as revealed by Medicare spending per patient in the last two years of life in five major large hospital teaching centers, all with salaried physicians. The costs itself are of some importance, but more importantly they reflect the style of medicine practiced at each medical center. From most expensive to least they are: UCLA Medical Center $93,842, Johns Hopkins Hospital $85,729, Massachusetts General Hospital $78,666, Cleveland Clinic Foundation $55,333 and Mayo Clinic $53,432. The reasons for these differences are variable but do not include physician entrepreneurship. Although the medical center was paid for the physician services on a fee-for-service basis, the physicians were paid by salary or in some cases on an hourly basis.

There are many known factors causing these differences and many that are harder to define. Certainly the idea that the physicians at the Mayo and Cleveland Clinics have access to information that is unavailable to UCLA, Mass. General and Johns Hopkins in this computer age is absurd. Thus comparative effectiveness research may be somewhat helpful, but it will not solve the problem of making the more expensive centers more like the less expensive ones. There is little to no difference in the availability of advanced technology, but outcomes are possibly worse in the more expensive centers. The more that is done having no benefit the greater the chance of mishaps. The more expensive hospitals have more beds; the patients are in the hospital more often and have more consultant and sub-specialist visits. Alas more (The American Way) is not better. There are of course other complicating factors; hospitals serving less privately insured patients need to maximize billing to compensate for the fact that government programs do not cover the costs of their activities. Even for salaried physicians there are subtle but real pressures to enhance income.

Each teaching center has its own medical culture which is the result of many forces, both historical and economic. The physicians of the Mayo Clinic have a long tradition of quick informal consultation, creating an environment of collegiality and helpfulness not requiring costly formal consultation. The patients at the Mayo and Cleveland Clinics frequently travel long distances for their care and are thus probably more amenable to a conservative approach and more likely to have private insurance; as time passed these institutions developed a more conservative practice of medicine utilizing less consultation, hospital days and ancillary testing.

The wide variations between the costs of care in these fine large teaching hospitals give pause to the concept of the widely touted proposal of bundled payments. This is because many of the patients in these prestigious hospitals are members of the managed care organizations that have evolved over time. Again, it is the medical culture, the skills the physicians have in history taking, physical diagnosis, interpretation of simple tests, ability to conceptualize cases, understanding probabilities and risk-to-benefit ratios along with the ability to communicate effectively.

This difference in medical culture as a primary cause of differences in cost is well documented by Dr. Atul Gawande in his article, *The Cost Conundrum,* in the June 1, 2009 New Yorker magazine. He compared two centers in Texas, McAllen and El Paso. McAllen spent twice as much ($15,000 vs. $7504) as El Paso per Medicare enrollee/year. Dr. Gawande found that McAllen's much higher costs were clearly due to an over-delivery of medical care by doctors, without better results.

Dr. Gawande reported on another community, Grand Junction, Colorado which practices in a fee-for-service setting. It had achieved Medicare's highest quality of care scores. They provide this excellence as one of the lowest health care cost areas in the country. The secret: the physicians have the courage and spirit of collegiality to meet regularly in small groups to review each other's charts and discuss how to improve care. This is in marked contrast to that found in most centers of aggregated impersonal computerized review. In addition they implemented a regional electronic medical record system reviewing each other's data, somewhat akin to my suggestion of a national medical record.

We need a medical culture on the national level that is willing to support and effectively teach each other while regularly reviewing cases. We must provide evidence-based care tailored to each patient's needs. This idea is similar to my suggestion of an active real time peer review system.

Answer to Question # 5

Why do we have so many sub-specialist and so few primary care doctors despite the fact that primary care doctors are the key to providing coordinated care of high quality for less cost? How can we can we remedy this imbalance in the near future?

According to David S. Goodman and Elliot S. Fisher (New England Journal of Medicine April 17, 2008),
"… between 1979 and 1999, the physician supply per capita grew by 45% in primary care, 118% among medical specialists, and 21% among surgical specialties, yet four of every five new physicians settled in regions where the supply was already high". Additionally the authors suggest that an unrestricted expansion of the physician supply would add to our fragmented specialist driven health care system because of the reimbursement systems underpayment for primary care. In Massachusetts since 1976 the physician-to-population ratio has doubled, now having the highest ratio including primary care in any state in the union, yet the medical society repeatedly makes claims of a physician shortage and patients report an ever increasing shortage of primary care. These authors hypothesize that besides a skewed physician distribution the reasons for this disparity is the inadequate payment for primary care services forcing physicians to spend less time with each patient, referring more cases to specialists and having hospitalists care for their hospitalized patients and restricting their practices to patients they already know. This is because new patients take much more time during their initial visit. Demonstrating that this problem is not a shortage of physician numbers, in the same issue of the Journal John K. Iglehart documented that in the U.S. there was an increase ratio of active physicians per 100,000 populations from 144.7 in 1960, to 278.5 in 2000 and expected to be 294.2 in 2020. As stated by Drs. Goodman & Fisher, the key for improvement is, "…..improve care coordination and chronic disease management; and accelerate efforts to reform payment systems so that they foster integration, coordination, and efficient care". I propose a payment system designed to adequately reimburse primary care physicians based on being able to spend 1hr. for each new patient and 1/2hour for each return patient and some time to follow their patients in the hospital.

Concerned about the primary care workforce Dr. John D. Goodson recently wrote (Annals Internal Medicine June1, 2010), about various aspects of the Patient Protection and Affordable Care Act (PPACA). With thirty-two million Americans newly insured, our specialty oriented physician workforce (70% specialists) will be poorly suited to provide adequate primary care services, health maintenance and coordinating care of those with chronic diseases.

The bill reauthorizes funding to expand primary care by providing financial assistance to programs and individuals for five years. The law establishes a National Health Care Workforce Commission to recommend actions by Congress to meet physician manpower needs. The problem is that in the past these programs have languished for lack of funds. With Medicare funding being curtailed to help fund this new law and expanding federal deficits, I doubt that these recommendations will reach reality.

The bill states that the Secretary of Health And Human Services should adjust the Resource Based Relative Value Scale (RBRVS) to enhance payment for primary care. The law provides for a 10% increase of present day payments to primary care physicians for five years and increases Medicaid payment to Medicare levels for 2 years. The problem is that the RBRVS is deeply flawed, grossly underpaying for evaluation and management; Congress since 1991 has been unable to fix it and it should be scraped. Medicare payments although higher than Medicaid are still inadequate to cover costs. Because of the long training period for physicians by the time these increases could affect decisions they will have expired, especially keeping in mind that it will take decades to increase the ratio of primary care to physician specialists.

A new Center for Medicare and Medicaid Innovation to help create new payment and service models was created. These new models would include expanded bundling, a single doctor payment for a disease event and follow-up, capitated payment that would cover hospital and doctor fees for an illness and a managed care type plan that would accrue monies to the providers for care costing less than expected. Other ideas to be tested are: a patient centered medical home (which in my opinion is what primary care physicians should be doing all the time) and Accountable Care Organizations that will contract with the Center of Medicare and Medicaid Services for complete medical care for a group of patients

retaining any profit. The problems are as I see them is that physicians have not been trained to avoid excessive testing and rely on clinical judgment, the public has unrealistic expectations of medical care along with demands for non beneficial care, and the mistrust of managed care type models have not been addressed.

The reasons that many young doctors wish further specialty training are not limited to economics. In this age of molecular biology and advanced patho-physiology young doctors want to learn more; this makes them better doctors not only in their area of specialization, but better doctors in general. Their skill set does not have to become narrower with appropriate further training. There are no active mechanisms in this law to change the physician and patient culture that pervades our system: too many tests, too much non-beneficial care, excessive demand for drugs and devices. The way to meet the need for greater primary care capability within a reasonable timeframe is to have medicine and pediatric sub-specialists provide primary care for their patients who do not have ready access to a primary care physician.

Answer to Question # 6

What has been the history of decreases in Medicare payments; have they been successful and what effect do you believe these policies have had on American medicine?

To meet budget demands Congress has made many downward adjustments to the payment schedule since Medicare's inception in 1965. When first created Medicare paid prevalent private insurance rates to hospitals and physicians; additionally, physicians were able to bill patients directly and could charge more than the Medicare rates, with the difference either paid by the patient or by supplemental insurance. Starting in 1972 because of federal budget issues Medicare imposed limits on physician payments using its newly defined "Medicare Economic Index". In the 1980's physicians became limited in billing patients above the Medicare payment rates and were made to submit bills directly to Medicare's intermediaries. Hospitals were limited in per diem nursing, room and board charges, ancillary (testing) charges and increases in costs/stay. 1984 was the beginning of Congress's unilateral control over Medicare fees. The prospective payment system was first introduced using Diagnosis Related Groups (DRG's) by which hospitals were prospectively paid according to diagnosis with possible modifiers. In 1992 Congress instituted a complex scheme, the Resource Based Relative Value Scale, as the method by which to reimburse physicians. Although ostensibly created to improve reimbursement for evaluation and management, this payment system has not done so and has instead dedicated more resources to specialization and technology[1]. Skilled nursing care, home health visits, rehabilitation and long term hospital stays were changed from reasonable cost to fixed federal government reimbursement also in 1992. Starting in 2000 hospital outpatient payments went from a cost-based to a fixed price system. A Robert Wood Johnson survey of physicians in 2009 found that 62% reported adequate reimbursement by private insurance while only 9.2% reported adequate reimbursement by traditional Medicare[2] (Medicaid pays even less). An American Hospital report (2008) found that for American hospitals in 2007, 58% received Medicare payments less than cost while 67% received Medicaid payments less than cost with total hospital losses from these programs totaling $32 billion[3]. Hospitals make up these losses by cross subsidization from private insurance. In essence because of these inadequate Medicare/Medicaid payment

amounts, premiums paid by those with private insurance subsidize these benefits. This is a hidden tax on the working middle class. Unfortunately Congress has not had the courage to either limit benefits or raise taxes to cover Medicare/Medicaid costs.

Has Congress's attempts at limiting Medicare payments because of budgetary concerns been successful in limiting costs? The Medicare Payment Advisory Commission (MEDPAC June 2008 Healthcare Spending and the Medicare Program) answered this question. "With a 9.7 percent annual average rate of growth, nominal Medicare spending grew considerably faster over the period from 1980 to 2006 than nominal growth in the economy, which averaged 6.2 percent per year". "Medicare spending has grown nearly 12-fold, from $37 billion in 1980 to $432 billion in 2007". Hospital and physician costs continued to increase in total and per capita with Medicare/enrollee growth in spending increasing at a rate that is about 1% lower than private insurance from 1970 through 2006. The growth rate of private insurance costs at only 1% greater than Medicare is quite remarkable since private insurance has cross subsidized Medicare and Medicaid at increasing amounts as these government programs have decreased their reimbursement rates.

Despite successive decreases in Medicare payment rates, Medicare spending has continued to parallel the increases in private insurance, but at a slightly lower rate. The reason is in large part the changes fostered by these decreases in Medicare payments to the culture of American medicine. The changes to American medicine include: inadequate primary care, excessive use of technology, outdated and uncoordinated information management, emergency departments feeling the need to completely work up patients rather than making the decision to admit or send home, the revolving door of nursing home patients to and from hospitals with no chance of overall benefit, hospitals need to over-utilize procedures and testing to stay solvent because of Medicare/Medicaid reimbursement, inadequate training of young doctors in the basics of history taking, physical diagnosis and lack of reliance on clinical judgment, drug and device companies advertising along with excessive influence over Congress and medical societies.

With these unsuccessful previous attempts to control Medicare spending by decreasing payments and not addressing the multitude of these other issues it does not bode well for the success of the recently passed health care reform law as it is supposedly financed in large part by decreasing Medicare spending.

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[1]Vladeck BC. Fixing Medicare's Physician Payment System, New England Journal of Medicine 2010;362:1955-1957 (PMID 20445166)
[2]http://www.rwjf.org/pr/product.jsp?id=48454 table 3
[3]http://www.aha.org/aha/content/2008/pdf/08-medicare-shortfall.pdf

Answer to question # 7

What is the effect on working Americans of private insurance having to subsidize Medicare and Medicaid?

A study published in 2006 using 1993-2001 data from California helps answer this question.[1]

1. California hospitals in general reflect those in the nation as a whole, but are more urban and with a higher percentage for-profit.
2. For each 10% decrease in Medicare and Medicaid payment there was a 1.7% and 0.37% increased cost to private payers respectively.
3. By 2001 hospital Medicare/Medicaid revenues were 9.77% below cost which caused a 1.66% increase in private payer costs.
4. These increases in private payer costs were $632,000/hospital/year totaling $210 million for the 311 general acute care hospitals.

The authors commented that reductions in Medicare/Medicaid payments to below cost could be addressed by hospitals in several different ways: lower staffing ratios, increases in efficiency, changes in service mix (emphasis on more costly procedures), less uncompensated care, lower profitability, and increased income from private insurance. All these mechanisms are used to varying degrees by different hospitals as government programs arbitrarily decrease payments.

But what does the average worker with a family of four pay for this cross-subsidization of government programs? This question was addressed by a 2008 study by the Milliman Consultants and Actuaries funded by the American Hospital Association, American Health Insurance Plans and two Blue Cross associations.[2]

Milliman examined national hospital and physician costs along with Medicare, Medicaid and private insurance payment data to calculate their results. Medicare and Medicaid paid 48.9 billion and 39.9 billion yearly less than and private insurance 88.8 billion more than the cost to offset the government programs underpayment. This amount raises private insurance costs for hospitals by 18% and doctors by 12%. The Milliman study calculated that for a family of four with private insurance cost-shifting increased their yearly health care premiums by

10.7% or $1,788. They reported that the employer paid $1,115 more and the family $673.

There is no question that our government must decrease its healthcare expenditures. The present method of arbitrarily decreasing reimbursement however, has not decreased expenditures and has caused cost-shifting to those with private insurance, in other-words a hidden tax that is decreasing the standard of living for working Americans. Cost-shifting has caused a detrimental sequence of events: private insurance becomes more expensive thus more companies and individuals drop their health insurance, many become uninsured and some become Medicaid patients, budgetary pressures lead to more decreases in government program payments thus causing more cost shifting, etc.

The prudent way to decrease expenditures for both governmental and private health insurance alike is to decrease health costs for both entities. This can be done by understanding and dealing with the reasons why we as a nation spend about $700 billion dollars/year (see question # 2) on non-beneficial inappropriate care. By doing the following we can decrease costs for both government and private insurance: Congressional amendments to the Patient Self Determination Act, The Americans with Disabilities Act, The Emergency Medical Treatment and Active Labor Act with the phrase, “within the bounds of good medical practice”, initiate the immediate availability of physician review to assure beneficial care, and create a Federal Health Care Bank to handle several administrative issues.

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[1]Zwanziger J and Bamezai A. Evidence of cost shifting in California hospitals. Health Affairs 2006; 25: 197-203 (PMID 16403754)

[2]Available on http://www.ahip.org/content/default.aspy?docid=2516 and click on full report (accessed 7/7/2010)

Answer to question # 8

What do you think is the effect on state budgets to have to assume about 50% of the costs of Medicaid?

Medicaid founded in 1965 along with Medicare, provides health care for U.S. citizens and legal immigrants who are under financial duress, with funding shared between the federal government and the states. As of 2008 the federal government funded, on average, about 56% of Medicaid costs with the remainder paid for by the individual states. On average, the states component amounted to 17% of their general fund spending. Eligibility for Medicaid unlike Medicare is relatively complex. Besides poverty other criteria include childhood, blindness, pregnancy, disability, residents of nursing homes and those with HIV/AIDS. In 2007 Medicaid provided insurance for 60.5 million people, including 29.5 million children and 5.6 million adults over age 65 (dual eligible with both Medicare & Medicaid), mostly for nursing home and long term chronic disease care. Medicaid payments subsidize about 60% of nursing home residents and about 37% of all child births. Without significant changes in the program, projections for future Medicaid costs as a percentage of state budgets is expected to reach 35% by the year 2030 (Deloitte Center for Health Solutions – 2010). This projection is based on our aging population (those with dual eligibility) which will require increasing amounts for the care of chronic conditions in both nursing homes and in the community. This projected large drain on state budgets is due to the unfortunate circumstance we have with our entitlement programs (Social Security, Medicare and Medicaid). They are in effect government sponsored ponzi schemes where one generation instead of paying for its future care (i.e. with health savings accounts) is dependent on its funding by the succeeding generation. With our aging population and less workers per retiree this method of funding becomes impossible. Another factor is the addition of about 14 million people to the Medicaid roles by the newly passed Patient Protection and Affordability Care Act with the federal government paying 100% of the additional care costs from 2014 through 2016, decreasing thereafter from 95% in 2017 to 90% in 2020. However, the states will have to absorb all the additional administrative costs estimated to be $32 billion from 2013 -2019 (Heritage Foundation Jan 14, 2010 Edmund Haislmaier). With the additional 14 million added to Medicaid we as a nation are

documenting that about 75-80 million Americans not of retirement age (about one-fourth of our total population) live near or below the poverty line. In essence many if not most of this segment of our population lack the skills to be productive in an advanced worldwide economy.

As of 2006 Medicaid costs to state budgets were $100.6 billion, while that of Kindergarten to grade 12, $208.3 billion. The recent recession has significantly increased state expenditures for Medicaid putting a further strain on the ability of the states to properly fund public education. Although both state and federal funding for Medicaid consumes many hundreds of billions of dollars annually it does not cover provider costs which necessitate cross-subsidization by private health insurance (see question #7).

As state funding is the major source for public education, the need to fund ever increasing Medicaid expenses by the states compromises our ability to adequately educate our young thereby putting our nation's future economic well being at risk. An Op-Ed in the Washington Post (Matt Miller, July 24, 2010) documents the recent decrease in the standard of living of many millions of our middle class. This is because post World War II we were the only advanced economy left intact so that the world had to buy from the U.S. There are now many advanced economies in the world and the U.S. is not developing the capital or the properly educated work force to re-industrialize our nation, increase our productivity and thus improve the standard of living for many Americans. We need a massive investment in public education, such as, much greater teacher to pupil ratios, longer school days and a 48 week school year, so that all Americans can participate in an advanced worldwide economy. For the states to afford this expenditure Medicaid would have to become a totally federal program necessitating a much more rational health care system (see question # 2).

Answer to question # 9

When can a patient reasonably utilize choice in care and in what situations are choices reasonably limited and who should determine when those conditions are reached?

Reasonable and desirable choices by patients

1. Avoid destructive behaviors such as tobacco, alcohol, illegal drugs, severe obesity, reckless driving, use of knives and guns.

2. Learn as much as possible about any present disease/s states and be diligent in caring for oneself.

3. Refuse any or all undesired treatments at any time within the confines of sound mind and of legal age.

4. Find a trusted physician so as to develop a therapeutic relationship, difficult in this age of 10 – 15 minute visits, to help create and sustain a constructive dialog between patient and physician.

5. Realize that the motive of drug and device advertizing directly to the public is to maximize profit and not necessarily maximize patient care.

6. Educate oneself as to realistic expectations from modern medicine and its limitations.

7. Learn about the cost of medical care in the United States, why it is so much higher than in other developed countries and how significantly this affects the standard of living of the middle class.

When are patient choices limited?

1. In obvious end-of-life situations, aggressive care is actually not in the patient's best interest as it prolongs suffering with no hope of benefit and often causes a more painful and protracted mourning period for the family.
2. In the presence of serious organ dysfunction, depending on the organ/s involved options become progressively limited as dysfunction progresses.

3. In technical situations requiring the acquisition of considerable medical knowledge and judgment the physician is in the best position to define the options and understand the limitations.

4. Patients frequently overestimate the capabilities of modern medicine leading to unrealistic requests for various treatments. In this situation it is the physician's responsibility to address these unrealistic expectations and not accede to the irrational.

Who should be making these decisions?

1. In most instances the patient along with the physician should decide on a care plan that is both reasonable and beneficial.

2. Physicians and the medical team must not deliver treatments knowing it/they will not be beneficial or superior to a simpler course of action.

Answer to question #10:

What do you think is the result of cobbling together various constituencies in trying to pass a health care reform bill?

Apparently because the Obama administration wanted to avoid the intense objections from the various constituencies that defeated the Clinton health plan, these parties were invited to participate in the planning and drafting of the new plan. Horse trading took place at the White House and intense lobbying involving hundreds of millions of dollars was part of the Congressional process. Some of the involved parties were: the AARP (representing those over 50 y/o), pharmaceutical companies, The American Medical Association (AMA), hospitals, unions and insurance companies.

The AARP became a firm supporter although approximately half of the funding for the new plan, $523 billion over ten years, was to come from decreases in Medicare spending, the national insurance plan for those 65 years and older. This age group is a major constituency of the AARP. Spending for regular Medicare enrollees will average a decrease of $22 in 2011 becoming $290 in 2014. For Medicare Advantage, planned cuts will be $195/enrollee in 2011 eventually reaching $1,267 in 2014. Please see question # 6 documenting that attempted decreases in spending during Medicare's 45 year history have not been successful. What did AARP receive in exchange for this support[1]?

1. AARP provides supplemental (Medigap) insurance for regular Medicare, the numbers of which will increase as Medicare Advantage shrinks.

2. AARP Medigap insurance is exempt from the prohibition of pre-existing condition exclusions.

3. AARP executives are exempt from the $500,000 insurance executive limitation on salary.

4. AARP insurance is except from the planned tax on insurance companies.

5. AARP insurance is exempt from the need to spend 85% of its premium income on medical claims.

I believe AARP like many other non-for-profits serves a national need; however, they should not be allowed to sell commercial products, i.e. insurance, credit cards, etc., for financial gain as these activities subvert its true mission.

The pharmaceutical companies as part of the deal with the White House spent $100 million on T.V. ads in favor of the Obama health care plan. In exchange for their support the industry was able to limit its losses.

1. Nothing in the bill would cost the industry more than $80 billion total, that would include closing the Medicare part D donut hole (the law closing the donut hole is extremely complex and will not be in full effect till 2020, For details see, " Closing Medicare's 'Drug Donut Hole'" by Christopher Weaver).

2. Medicare would not negotiate drug prices as a single entity.

3. Re-importation of drugs to obtain lower prices would continue to be prohibited.

4. Exclusivity for the new field of biologic drugs (drugs from living cells) will be extended for twelve years versus the originally proposed five years.

Not only did the pharmaceutical industry succeed in protecting its high profits, but there was no attempt to objectify drug research, such as by having the funds funneled through the National Institutes of Health to assure good experimental design and the honest reporting of results.

The American Medical Association (AMA) did not mount an objection to the reform bill and was thus able to obtain several concessions.

1. A $300 tax on physicians who serve Medicare and Medicaid patients (this tax was proposed in spite of the fact that Medicare and Medicaid do not even pay cost for the services received) was defeated.

2. A tax on the lucrative cosmetic surgery industry was defeated.

3. A 5% decrease in payment to the top 10% of Medicare billers was defeated.

4. The AMA was able to obtain a temporary slight increase in reimbursement for primary care doctors instead of a decrease.

5. The AMA was able to maintain its monopoly on billing codes which accounts for about $80 million/year.

Each year since the Balance Budget Act of 1997 which created the sustainable growth rate (SGR) payment method for physicians there was supposed to be a decrease in Medicare physician payments if physician billing costs increased to a greater extent than the overall economy. If in any given year Congress overrides the decrease it becomes cumulative for the succeeding year. Congress has prevented these decreases over the years so that the projected decrease this year was just over 21%. The AMA did not accomplish its major goal of a repeal of this formula because of the billions of dollars this would have added to the cost of health care reform. A temporary halt to the decrease was passed with the resolution of this issue still in doubt. More importantly, the Congress did not require the AMA to develop the tools needed for doctors to care for all Americans at a cost in line with that of other industrialized countries, which accounts for about $80 million/year.

Hospitals hoped to come out about even from health care reform.

1. Hospitals gained by having many fewer non-paying patients when the bill is in full effect.

2. Many of these newly insured patients will be covered by Medicaid; therefore the hospitals will still lose money providing care to this population.

3. Hospitals also accepted a further decrease in Medicare payments of $155 billion over the next ten years; thus hospitals with mostly Medicare and

Medicaid patients will face severe financial stress while those with mostly privately insured patients will prosper.

Hospitals could have created a physician and nurse mechanism to eliminate non-beneficial care thus saving Medicare and Medicaid substantial amounts, and then they would have been in a better position to argue for higher payments for appropriate care that would more than cover their costs.

Unions' objective was to postpone or eliminate the proposed tax on Cadillac health insurance plans. In a deal with the White House this tax was postponed till 2018 to allow time for the unions to restructure their contracts with employers. The unions were not asked to develop a system to minimize non-beneficial care which would be in their interest as our excessive health care costs are a major reason why working families have not seen an increase in their standard of living. Our excessive health care cost, by decreasing the competitiveness of our goods in the world market, has also led to a decrease of good paying manufacturing jobs in this country.

The insurance industry was very active politically trying to make this law as friendly as possible to its interests. It received several benefits.

1. The industry successfully blocked a government run public option.

2. The industry gained 30 million new customers with government subsidies.

3. Beginning in 2014 insurers must provide a specified minimum of benefits for which they can charge more than for catastrophic insurance.

On the other hand there were several financial negatives for the insurance industry.

1. Insurance companies will no longer be able to deny coverage because of pre-existing conditions.

2. There will be no life time limits on the amount that can be paid.

3. There will be no waiting period before coverage will take effect.

4. There will be no, “rescission”, dropping coverage when adults become sick.

5. Profits on Medicare Advantage programs will be curtailed as payments will significantly decrease.

The lobbying activity directed to Congress was intense to ensure that these special interests groups protected their turf[2].

1. In 2009 total lobbying costs were $3.47 billion.

2. The health care sector accounted for $544 million.

3. The pharmaceutical industry spent $267 million, the largest lobbying effort ever spent by a single industry in one year.

4. The entire health industry spent $1.4 million /day.

5. In 2009 more than 3,300 lobbyists were working on health care, 6/Congressperson.

6. About 330 of these lobbyists were former Congressional staffers or a member of Congress.

7. Senator Max Baucus, chair of the Senate Finance Committee that crafted the bill, received $2 million for his reelection campaigns from the health sector over the past five years.

8. Other members of Senate Committee on Finance, Democrats and Republicans, also received large sums for their reelection campaigns.

9. In all the health industry contributed $27.6 million in campaign contributions to members of Congress in 2009 and early 2010.

10. In 2008 President Obama received campaign funds of $19.5 million from the health industry.

In summary the health reform bill, The Patient Protection and Affordable Care Act, is in reality a very expensive insurance law the crafters of which did not make the effort to try to understand the forces presently at work causing us to spend so much more per person than any other modern society. The proven amounts of non-beneficial care delivered in this country are truly staggering. Instead we have a bill that does meet the worthwhile goal of nearly universal coverage, but at a price our nation cannot afford.

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[1]www.john-goodman-blog.com/war-on-seniors (accessed 8/2/2010)

[2]Tomasky M. The Money fighting health care reform. The New York Review of Books 2010; 57:1-8

Section 2 - Road Map to Affordable Coverage

Introduction

Why does health care reform have to mean spending more on health care? We already spend much more per person than any other country. We in America practice an exorbitantly expensive style of medicine. We have de-emphasized the trusting relationship between patient and physician while over-using technology, drugs and devices in large part fostered by the Congress via its control over the Medicare payment schedule. Instead of addressing the more complex situation of the way we practice medicine in this country and its causes, our political class has chosen to focus on the results of our excessive spending, insurance costs. There are solutions to this problem; we can as a nation cover all Americans for a lesser percentage of gross domestic product that is more in-line with that of other developed countries. This would have a salutary effect on our economy. We can correct our health care system if we understand the flaws and realistically correct them.

Major Flaws in our Health Care System

- Medicare's payment schedule, which as the largest insurer drives the industry, has chronically under-funded the doctor-patient relationship and over-funded technology, drugs and devices, and is responsible for a profound negative effect on the practice of medicine in the United States. The under-funding of the time patients and physicians can carefully review the issues has caused a decrease in preventative care and poor management of the chronically ill.
- More and more use of expensive technology without evidence of superiority over existing, less costly methods takes advantage of lucrative quirks in the Medicare payment schedule. Some examples are proton accelerators for prostate cancer and the use of cardiac stents in patients whose conditions are just as easily managed with medication.
- There is no nationwide, consistent system of oversight by qualified experts – physicians and nurses – to ensure that *only* appropriate care is being delivered. One expert after another has said that inappropriate care is the

biggest culprit in out-of-control costs - estimated at over $700 billion per year.

- Cardiopulmonary resuscitation (CPR) is automatically performed unless a "Do Not Resuscitate Order" is written. CPR by default began in the 1960s when the typical hospital population was much younger. Today that population is much older, yet we spend billions a year on CPR, mostly on end-of-life patients who have no chance of survival and who suffer from the procedure.
- Hospital and physician administrative costs have become nearly unmanageable due to the number of staff needed to handle the wide range of insurance plans because of state mandates and many employers providing a multitude of different coverages. The same is true for the insurance companies themselves. All those costs are passed on and contribute to ever-burgeoning healthcare expenses.
- Device and drug company advertising directly to the public helps promote an increasing sense of consumerism. Patients and their families have a virtual smorgasbord of drugs, devices, and procedures, all attractively packaged in the ads, that they can demand whether they'd be of any benefit or not. Unfortunately, many physicians are loathe saying no to them.
- Presently government programs, Medicare and Medicaid, are being subsidized by the privately insured. We have not created a system whereby each generation pays for most of its own health care. The present system of depending on younger citizens to fund the health care of the elderly is, because of demographic changes, no longer sustainable.

The problems in our healthcare system have become so complicated and intertwined that remedies involving huge additional spending are not the solution. The objective should be to care for all our citizens at a reasonable rate that brings the percentage of gross domestic product spent on health care more in line with that of other industrialized countries, thus increasing our global competitiveness. If the following recommendations are adopted, these goals would be realized.

Recommendation 1: Specific Actions by Congress

Amend the Patient Self Determination Act, the Americans with Disabilities Act and the Emergency Medical & Labor Act – The original intent of these acts was to give patients more voice in their care and the ability to refuse even beneficial treatment, protect the disabled, and prevent hospital emergency rooms from turning away patients because of a lack of ability to pay. Frequently these acts have morphed into a license to receive care or treatment, whether it is beneficial or not. This has caused many thoughtful physicians who have the best interests of their patients at heart of having to concern themselves about the possibility of legal action. Alternatively there are physicians who knowingly or unknowingly deliver non-beneficial care because the treatments and procedures are handsomely reimbursed by third parties. Amending these laws to include a phrase such as "within the boundaries of acceptable medical standards" would have a dramatic impact on the way we practice medicine in the United States. The medical profession would have to collaborate on difficult cases, exercise more judgment, individualize decisions on each patient, and work to decrease non-beneficial inappropriate care. Importantly, patients and physicians would have to dialogue regarding the rationality of their medical plans. Thus Congress would be actively endorsing recommendations 2 & 3.

Create A Federal Health Care Clearing House and Bank **-** Create a separately chartered, independent federal agency – like the Federal Reserve System – that would be a central clearinghouse for our entire health care industry – public and private. I would call it a "Healthcare Bank" which would, like the Federal Reserve System regarding monetary policy, insulate health care from the politics of Congress. The Healthcare Bank would coordinate and perform many tasks now done by insurers and healthcare providers. It would not only simplify the system and make it more uniform, it would decrease administrative costs to the tune of billions of dollars a year. At the same time it would maintain our present mix of private and governmental insurers.

The Healthcare Bank would:

1. Convene a biannual meeting of representatives from all insurance entities and the national peer review panel (see Recommendation 3) to define five

standardized national insurance packages. The lowest cost plans 1 & 2 would cover all essential appropriate medical services and would be available to all with no exclusions for preexisting conditions. Plan 2 would be the government equivalent of plan 1, federally funded and covering the poor and uninsured, thus eliminating Medicaid. As medical costs decreased the number of uninsured would decrease and the accrued savings would be more than adequate to roll in coverage for the remaining uninsured. At the other end of the scale, plan 5 would be considerably more expensive and include extras such as podiatry, massage, health club memberships, plastic surgery, etc. Plans 3&4 would be successive gradations between plans 1-2& 5. This would replace the present thousands of plans funded by third party payers and thus save many billions in administrative costs. Insurers would compete by lowering costs and by initiating innovative programs such as weight, diabetes and blood pressure control, home health services for the elderly, etc. Co-pays and minor outpatient costs could be paid via health savings accounts with contributions by the federal government for those in plan 2. These health savings accounts would accumulate funds tax free with yearly contributions so that by the time of retirement most health care would be funded by these accounts. Medicare would then be available for catastrophic coverage. Any monies remaining after the demise of the individual would be inheritable.

The Bank would also ensure that all insurers, public and private, adequately fund hospital and nursing home care thus eliminating cost shifting. This would preclude the need for hospitals and nursing homes to stress often unnecessary, non-beneficial technological and procedural care to maintain solvency.

2. Determine fees so that physicians and patients would have adequate time to thoroughly discuss the medical issues at hand, at least ½ hour per out-patient visit, and allow primary care physicians to visit their patients when hospitalized. To meet the immediate primary care shortage, internal medicine sub-specialists would be recruited to also provide primary care.

3. Establish a central computer system through which all billing and payments takes place and through which all insurers are paid.

4. Maintain an electronic medical record system for the entire nation with multi-layered safeguards to insure privacy.

5. Require that all hospitals, nursing homes, other health providers and insurance entities (public and private) adjust their computer programs so that all could interface with the bank's computers, with the proper privacy safeguards. The bank would charge a small fee for each transaction which would cover the costs for initiating and maintaining these electronic services without consuming additional federal funds.

6. Fund The National Institutes of Health (our major national research endeavor) by collecting monies from all insurers, governmental and private, in proportion to the percentage of the population covered by each. This type of research is an investment for the future and should be funded by all carriers, not just the federal government.

7. Require all drug and device companies to fund their clinical research through the National Institutes of Health which would oversee the experimental design and the results, thus removing the conflicts of interest that exist in the present system. The Healthcare Bank would collect and distribute the funds. This would eliminate the need for a proposed expensive new bureaucracy, a Healthcare Comparative Effectiveness Research Institute, because information would be developed prospectively rather than retrospectively at no cost to the government.

8. Fund graduate medical education (residencies & fellowships) through funding from all carriers in proportion to their market share and make payments directly to the educational entities. This would ensure that post graduate physician training is primarily a training experience.

9. Pay the salaries and staff of the expanded peer review committees (see Recommendation 3).

10. Be funded by fees paid by all carriers in proportion to their market share. The Healthcare Bank, like the Federal Reserve, would report to Congress on a fixed schedule.

11. Promote additional training for nurses (probably three year in-hospital programs) to rectify the present and predicted future severe nursing shortage. Nurses are the foundation of any health care system and will be especially needed as our population ages.

12. Require all hospitals to use an updated admission form, see Appendix, described in Recommendation 2.

Recommendation 2: A New Style of Hospital Admission Form

While noble in their intent, Advance Directives have proven to be ineffective. Only about 20% of Americans have executed an advance directive and only about half of these have discussed their wishes with their physician. Without one, most hospitals and nursing homes assume that the patient wishes every conceivable means of medical therapy, even if inappropriate for that particular patient. Another problem with advance directives is that it asks the person to make a decision about what type of care would be wanted at some time in the future. However, one could not possibly know what the clinical situation will be at that time.

1. This new style of hospital admission form (Appendix 1), to be completed within a reasonable time frame after each hospital admission, would serve as a fresh and timely advance directive. Because admission to a hospital is an extremely stressful time for the patient and family, the medical team can facilitate the completion of an up-to-date advanced directive, helping the patient/family make rational decisions about which therapies are indicated and among them those that are not wanted. During the discussion about the form the physician can clarify the fact that only beneficial care can be administered. These discussions help create a mutual understanding between the patient/family and the medical team regarding a rational care plan based on medical knowledge adapted for that particular individual.

2. The form would also create a timely appeal mechanism to resolve any disagreement between the patient/family and the medical team. The appeal team would consist of two doctors and a nurse, in effect an expanded peer review committee (see Recommendation 3).

3. Using this form would eliminate cardiopulmonary resuscitation (CPR) by default – that is performing CPR whether it would benefit the patient or not. CPR - the restarting of heartbeat and breathing - was first developed in the early 1960s, before Medicare, when the hospital patient population was much younger. So it was reasonable to be initiated automatically whenever there was a cardiac arrest because the patients had a more reasonable chance of survival and recovery. However, the hospital population is now much older and many are in an end-of-life situation. Despite this change in demographics the custom still remains to attempt CPR automatically, even in patients with end-stage disease despite great discomfit to the dying patient. This occurs unless a specific order is written to avoid the procedure. The new admission form would correct this problem by making cardiopulmonary resuscitation an ordered event to be used in the appropriate circumstance. This would save many thousands of patients a great deal of discomfort and preserve billions of dollars of resources.

Recommendation 3: Expanded Peer Review Committees (two physicians & a nurse)

No healthcare system, universal or otherwise, can be efficient, cost effective, and truly serve the best interests of patients without peer review. That is - consistent, uniform, organized oversight by senior physicians and nurses with knowledge and experience in the practice of medicine and patient/family support. This would take the form of expanded peer review committees organized at the local and national level created through Congressional action through the recommended amendments to The Patient Self Determination Act, The Americans with Disabilities Act and the Emergency Medical & Labor Act described in Recommendation 1.

Expanded peer review would be by medically trained professionals who understand the need to asses every situation based on its own individual characteristics. It will also be the key to addressing the issues that have made our healthcare system so dysfunctional. Issues like ICU and coronary artery stent overuse, inappropriate transferring of nursing home patients to hospitals even though they cannot benefit from hospital based care, and many other situations would be addressed by these peer review committees. Withholding care that is of no value is NOT rationing, but in reality is just the opposite. When resources are conserved and used wisely and appropriately, rationing will not be necessary, and every patient can be treated as a unique individual with unique needs without regard to cost.

Expanded peer review committees would be in every area in the country. These committees would have no financial affiliation with the various institutions. They would have the power to cease payment (after initial discussion) for care that offers no benefit to the patient, and mediate disagreements between admitting physicians and families over options for care.

These appointments would be salaried; therefore committee members would have no financial interest in their decisions (the basic flaw in managed care). These salaries would be paid for by a consortium of all insurers through the Healthcare Bank.

A national committee also composed of senior physicians and nurses would oversee the entire system for the nation. National appointments would be similar to those of The Federal Reserve Bank. Local committee nominations would follow guidelines established by the national committee.

The peer review committees would ensure that the Congressional amendments to the above mentioned acts are indeed in effect and that national standards be created. This would alleviate the discrepancies in care so well documented by the Dartmouth Atlas of Healthcare.

Many physicians would object to the system, thinking that it would interfere with their autonomy and could threaten their income. Many others, however, would embrace it for three reasons:

1. It would reintroduce the primacy of the patient-doctor relationship for all physicians. It would save more than enough resources so that we as a nation could provide universal coverage while simultaneously decreasing our total health care costs, thus greatly improving our economy.

2. It would provide support for the physicians who truly try to do their best for their patients, but now have to concern themselves with legal and economic issues.

3. It would rightfully place physicians at the core of healthcare reform to deal with excessive costs, lack of care for millions of our citizens, the public's dissatisfaction with the system and our less than stellar health outcomes compared to other developed nations.

Importantly, expanded peer review committees through their power to withhold payment for inappropriate care would send a powerful message that this sort of medical practice would no longer be acceptable. It would not take long before we saw a significant drop in billing for useless technological procedures and treatments. As a result, healthcare costs would plummet by billions of dollars.

Summary

These three reforms to our health care system – Congressional action inserting language in existing acts so that only medically reasonable treatments are delivered, creating a Healthcare Bank, a new style of hospital admission form, and a system of expanded peer review committees - would ensure excellent care for all our citizens while significantly lowering our health care costs.

New Hospital Admission Form

Appropriate Care Hospital Admission Form

Name _____ Med. Record #_____
D.O.B. _____ Date _____

1. Is Patient capable of decision making: Yes ( ) No ( )
   If No, who is responsible? Next of Kin/ guardian: _____
   phone_____

2. Cardiopulmonary Resuscitation (CPR) is ordered on this patient: Yes ( ) No ( )

   Place the following restrictions on CPR. DO NOT DO THE FOLLOWING:
   ( ) intubation ( ) chest compression ( ) resuscitation drugs ( ) cardioversion

3. When thought to be in an end of life situation by the medical team, I want to receive palliative care and consider placement in hospice: Yes ( ) No ( )
   If No, the appropriate care I want is: _____

5. Other therapies this patient has chosen to refuse even though medically indicated are:

5. Other Stipulations or Concerns:

This form serves as a guide for physicians to carry out the wishes of the patient. There is a hospital physician team responsible for oversight of appropriate care, whose goal is to help define beneficial care appropriate for the patient (the benefit to the patient significantly exceeds the risks). An expanded peer review care committee is available for the patient should conflict arise.

Physician Signature _____
Patient Signature _____
Witness Signature _____

Section 3 – Essays from my Blog

This is a collection of essays from my blog, www.drkennethfisher.blogspot.com divided into three parts. Part A and Part B provide the reader insights into the fundamental problems with today's health care system and the flaws in the new health care reform law, The Patient Protection and Affordable Care Act. Part C deals with what steps are necessary to create universal coverage for all Americans and importantly, at a cost that will improve not harm our national economy.

Part A: Problems with Today's System

Can Medical Ethics Taken to the Extreme be Detrimental?

I believe it can. Here's a recent example.

An 18-month old child with a rare and always fatal disease had been on life support in a Texas hospital for five months. The Texas physicians, with the agreement of the hospital ethics committee wanted to discontinue life support because the child had no chance of recovery. His death was imminent and certain. Texas has a Futility Law that provides for a limited time period before the hospital, with the agreement of the ethics committee, can discontinue all but supportive care. His mother wanted life support continued and with the help of others, appealed to the courts to prevent the Texas Futility Law from being activated in this case. The child died before the judge's final ruling.

Dr. Robert D. Truog, Professor of Medical Ethics and Anesthesia (pediatrics) Harvard Medical School, wrote about this case in a perspective article in the New England Journal of Medicine. (1) In Dr. Troug's view, since the child was severely neurologically impaired and could not perceive pain, the doctor's claim that he was having a painful death was not valid. But what about the indignities suffered by this child with feeding tubes, constant IVs, multiple blood tests and the ventilator tube to keep him breathing? The physician's concern about the dignity of the child's death was of little concern to Dr. Troug, the child's mother and others who joined in the legal battle.

These are extremely unfortunate and painful situations that require delicacy and understanding, but I believe, must be addressed with a sense of reality. If, indeed, the total weight of medical knowledge shows that a patient will not benefit from therapy, then providing such therapies because of patient/family demands, means physicians are not to express or develop judgment, but must rather use their skills as technicians at the bidding of others.

There is no doubt that some form of due process should be in place to insure against human misjudgment and provide fairness to the patient/family. But Dr. Troug's view that the judicial system is the only source of due process is an extreme view that says honesty and fairness is impossible in a medical setting. I share Dr. Troug's respect for the need to be fair to minority views, but that

fairness does not, in my opinion, extend to family desires that are totally inconsistent with the reality of the situation. This is just the sort of situation that would benefit from a nationwide system of appropriate care committees (See my March 1,2008 post about Appropriate Care Committees for more details.) The courts are not the places to decide medical issues.

Dr. Troug's conclusion that physicians are incapable of dealing kindly but appropriately with end of life situations along with ill-conceived judicial opinions (2), have had a serious negative impact on American medicine. This has led to over 550,000 deaths in ICUs yearly with its overuse of technology and procedures, lack of spirituality at tremendous cost to our society (3).

In my opinion, physicians must learn how to deal fairly with the many difficult and sometimes tragic situations they confront on a daily basis, but cannot relegate conflict to others, especially to the courts. Doctors must learn to use the profession's ever increasing treatment options wisely for the benefit of their patients and for our society. A family's demand for treatment does not relieve the physician of responsibility to deliver care within the confines of medical knowledge and with the best interest of the patient at heart.

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1. Troug, RD. Tackling Medical Futility in Texas. New England Journal of Medicine 2007;351:1-3 (PMID 17611201)

2. Annas, GJ. Asking the courts to settle standard of emergency care – the case of Baby K. New England Journal of Medicine 1994;330:1542-1545 (PMID 8164726)

3. Angus, DC, Barnato AE, Linde-Zwirble, WT, et al. Use of intensive care at the end of life in the United States: an epidemiologic study. Critical Care Medicine 2004;32:638-643 (PMID 15090940)

Robbing Peter to Pay Paul-The Fall of Primary Care and the Rise of Technology Medicine

If Peter is the primary care physician then Paul is the obsession we in American medicine have with technology and procedures, which frequently are of no benefit to patients. Technology used wisely can be wonderful, but when used inappropriately is potentially harmful to the patient and wasteful of resources. Perhaps the most painful example of this obsession is in end-of-life care, typified by the recent publication of articles extolling the virtues of end-of-life care administered in the intensive care unit (ICU).(1)

Some of the many reasons why the concept of knowingly providing end-of-life care in the ICU is inappropriate are:

1. Once it has become obvious to the ICU team that an end-of-life situation is at hand, the patient needs symptom control and along with the family, spiritual support. However, ICU care is technology intensive, with an inherent inability to eschew that technology regardless of its appropriateness. This was admitted by the authors of the above quoted article in their response to my letter. (2)

2. Certainly there are much better venues able to provide spiritual support than an intensive care unit with its hustle-bustle and crisis like atmosphere.

3. Energies expended by the medical care team on end-of-life patients in the ICU are not spent on other patients who have the capacity to improve and for which ICUs were developed.

4. The difference in cost between end-of-life care in a regular hospital bed and the ICU is staggering. (3) Some ICU doctors argue that fixed costs (nursing and equipment) in the ICU are such that decreasing the number of patients would not result in savings. (4) However, fixed costs would be decreased if patients who should be in hospice were not admitted to the ICU. Unfortunately hospitals have become mesmerized and addicted to this additional income!

But where is the primary care doctor in this situation, the physician the patient and family has learned to trust over the years and should guide patients during tough times? There is no mention of her/him in the ICU literature and from a national perspective because of severe financial constraints, primary care is in crisis. (5) This ICU scenario is a microcosm of our medical system. Technology is frequently used inappropriately, patients do not receive the care they need, patients who would benefit from more attention do not receive it because of diverted efforts, and the medical system pays exorbitantly for services that cannot accomplish a worthwhile goal. Because of the huge amount of funds going for nonsensical technology and procedures, primary care, the cornerstone of any nation's health system, withers on the vine. This is a national disaster that must be addressed before our health care system can deliver adequate care to all our population. In future articles, I will discuss a physician based appropriate care committee review system with financial authority on the local, state and national level, to address patients on an individual basis. This would go a long way to solve this problem.

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1. Lautrette A, Darmon M, Megarbane B, et al. A communication strategy and brochure for relatives of patients dying in the ICU. New England Journal of Medicine, 2007;356:469-78. (PMID 17267907)
2. Fisher KA. Communication about dying in the ICU. Letter to the editor. New England Journal of Medicine, 2007;356:2004 (PMID 17506162)
3. Angus DC, Barnato AE, Linde-Zwirbl WT, et al. Use of intensive care at the end-of-life in the United States: an epidemiologic study. Critical Care Medicine, 2004;32:638-43. (PMID 15090940)
4. Luce JM, Rubenfeld GD. Can health care costs be reduced by limiting intensive care at the end-of-life? American Journal of Respiratory Critical Care Medicine, 2002;165:750-4. (PMID 11897638)
5. Public Policy Committee of The American College of Physicians. Achieving a high performance health care system with universal access: what the United States can learn from other countries. Annals of Internal Medicine, 2008;148:55-75 (PMID 18056654)

Cardiopulmonary Resuscitation

In my book, “In Defiance of Death: Exposing the Real Costs of End-Of-Life Care”, I discussed the uses and abuses of in-hospital cardiopulmonary resuscitation (CPR). This procedure involves attempting to restart the heart after it has stopped beating. I quoted a paper that found only 10.5% of these patients were alive one year later. I mentioned that if we could decrease the number of resuscitations in half, by excluding those patients with known terminal disease, not only would we save dollars, but more importantly we would allow thousands of patients to have a more dignified and peaceful death.

I quoted Dr. Blackhall who, in The New England Journal (1987), discussed the concepts of patient autonomy and physician responsibility. Basically, he said that if the medical assessment is that CPR has even a remote chance of success it should be offered and the patient with autonomy has the right to refuse the procedure. However, if there is no chance of success, physician responsibility would dictate that CPR should not be done regardless of the wishes of the patient/family. In these situations Dr. Blackhall concluded that both patient and physician must understand that modern medicine cannot indefinitely postpone death.

I also pointed out that since the early 1960's CPR is performed in the hospital as the default position unless there is a specific do not resuscitate order (DNR). This frequently leads to confusion, with CPR being attempted in the majority of cases when it is obvious that it would not be successful. This is the reason that a small percentage of patients receiving CPR leave the hospital alive and fewer still are alive a year later. I suggested a new hospital admission form that would make CPR an ordered event and create an updated advanced directive with physician input to ensure medical feasibility. I also suggested an appeal mechanism in cases of misunderstandings or differences in opinion.

So what is the latest data? Are we using CPR more or less wisely? Dr. W.J. Ehlenbach and colleagues recently published results using Medicare data (reimbursement codes) from 1992-2005 in the July 2, 2009 New England Journal of Medicine. They found 18.3% of CPR patients left the hospital alive. There was

no increase in the survival rate over this time course. They found an incidence of 2.73 CPR attempts per 1000 Medicare hospital admissions with survival less for men, the most elderly, those with co-existing disease and those admitted from skilled nursing homes. Strikingly they found that the proportion of patients dying in the hospital having undergone CPR actually increased during this time period. Fewer survivors of CPR were discharged home over the course of the study. People of African descent had higher rates of CPR but with less survival.

Is it just CPR that is now being increasingly used more inappropriately, or is it a reflection of the present style of medicine in this country? In my mind there is no doubt that it is a reflection of our present medical culture. There are presently no mechanisms whereby physicians collectively attempt to use our ever-expanding medical arsenal in an individualized rational manner. We presently have a business model in what is fundamentally a non-business enterprise. These are some of the reasons why we spend much more per person than any other country, have millions uninsured and inferior outcomes. Until these and other basic problems (i.e. lack of primary care, the politically driven Medicare payment system) are addressed, I believe our present attempts at health care reform will be unsuccessful.

Hidden Insight in the Dartmouth Atlas of Health Care

Many quote the Dartmouth Atlas of Health Care (www.dartmouthatlas.org) as suggesting we spend about $700 billion/year on inappropriate non-beneficial care. This approximate number is also supported by the McKinsey Global Institute which demonstrated that other industrial nations spend more per person on health care as their gross domestic product (GDP) increases. They made a graph plotting spending per person on the Y-Axis versus GDP on the X-Axis. The result is a tight curve with all countries bending upward toward the right except for one country that is way above the curve. That country is ours, the United States with excess expenditures of about $700 billion/yr. It should be noted that our results in healthy lives are among the worst.

The Dartmouth map demonstrates that the sites spending the most with no additional benefit, with a few notable exceptions, are our major teaching centers. In the need to perform procedures to generate the necessary cash to cover their considerable overheads, these centers are training our young doctors to do, not to think! It is startling to realize that seats of learning have abandoned their basic principles under their need to tout the latest gadgets to attract patients and meet their needs for funds. Our major medical centers are in a technological arms race with each other. They are in competition for cases that need intensive care units, complex testing and therapies requiring ever increasing expensive technologies. Many great things are accomplished for many patients. However, the ability to discern who will or will not benefit is being lost in many of our great institutions. That is the hidden secret of The Dartmouth Atlas of Health Care.

In the Sunday July 26, 2009 New York Times David Leonhardt wrote, “Even when doctors order costly treatments with serious side effects and little evidence of their being effective, as studies find is common, patients are loath to question the decision. Instead of blaming such treatments for the rising cost of medicine, many people are inclined to blame forces that health economists say are far less important, like greedy insurance companies or onerous malpractice laws”. I believe it would be beneficial if our political leaders would read and reread these words.

Physician fees have to be adjusted on an individual case by case basis. The cardiologist who gets up at 3:00 am to do a cardiac catheterization and stenting for a patient in the midst of a heart attack is doing a fine service saving heart muscle and should be well compensated. The same cardiologist who at 10:30 am is doing the same procedure on a patient with stable mild chest pain (angina) should not be reimbursed because medical therapy has been shown to be equally effective, thus the need to individualize each case.

My suggestion to address this issue of appropriateness is thorough peer review. This review would have as one of their functions, sporadically reviewing cases for the appropriateness of their care. After an initial warning, payment would be withheld for care deemed non-beneficial. Doctors and hospital administrators are smart; they would quickly learn to limit their inappropriate non-beneficial care. Some of the saving could be used to reform the Medicare payment schedule to hospitals so that the massive cost shifting now taking place need not occur.

Patient Knowledge Versus Consumerism

Patient education is a component of good health care. Patients should know how to stay healthy and, if necessary, care for disease processes. However, when health care becomes like any other consumer item, the whole process becomes distorted. Unlike consumer products today's medicine is extremely complex with real limitations as to what can be accomplished. Ignoring these limitations leads to excessive testing and treatments, i.e. consumerism.

It is advantageous for a patient working with a trusted physician to understand the necessity to control blood pressure, control diabetes, control weight and eliminate harmful habits (tobacco, alcohol, illegal drugs, violence, etc.). Every literate American has access to abundant sources of information regarding health issues. Unfortunately, because of dysfunctional reimbursement policies, driven by Medicare as the nation's largest insurer, for many patients there is little quality time between physician and patient. It then becomes difficult to develop the healing relationship so important for good health care. Frequently patient education develops into unrealistic beliefs in the power of medicine with inappropriate expectations leading to consumerism. In complex situations in patients with multiple health issues there is no substitute for medical judgment. This can only be obtained with formal training and years of experience.

Indeed it takes more training to take care of seriously ill patients than to fly a jet liner. Yet it is inconceivable that a jet pilot when facing a problem, instead of using his experience and judgment, would have the passengers vote on what to do. However, unlike the pilot, in today's medical practice it is common for physicians to place the task of medical judgment on the patient/family frequently resulting in irrational care. This often leads to patient suffering and the wasting of valuable resources.

This exaggerated sense of patient autonomy along with the fear of legal action has augmented medical consumerism. This problem has been enhanced by drug and device advertisements directly to the public and by the medical profession's undue reliance on the legal system to decide what are, in effect, medical

questions. Instead of our various medical societies forming referral mechanisms to help decide difficult issues, hospitals and doctors have abdicated this responsibility to the courts with the result being an ever-present fear of legal action.

As long ago as October 16, 1975 Dr. Franz Ingelfinger, then editor of the New England Journal of Medicine, wrote about physicians allowing the legal community to be the referee in difficult medical issues. He wrote:

"Serious questions may also be raised concerning the propriety or usefulness of legal proceedings when essentially medical questions are at issue…..dependence on the lawyer in reaching essentially medical decisions will continue, however, unless organized medicine can develop its own effective system of in-house arbitration….."

It should be noted that till this day our medical societies have not answered this challenge. Again, in May, 1994 (New England Journal of Medicine) while discussing the Baby K court case, an encephalic baby with no chance of recovery, George J. Annas had a similar message. He commented that for medicine to avoid becoming a consumer commodity and thus unbearably expensive requiring control by payers, physicians will have to set standards and follow them. Again organized medicine did not and has not responded.

A few weeks ago (November 2009) a talented second year resident told me that, in his opinion, American medicine is no longer about treating patients' problems. It has become a hospitality industry focused on customer satisfaction regardless of the appropriateness of the medical plan.

For health care reform to be successful we have to insist that our medical societies set up procedures so that patients are treated as individuals, each with unique needs. At the same time mechanisms must be established so that we uniformly practice high quality medicine with evidence-based use of resources. We must have expanded peer review so that difficult situations and overuse can be quickly resolved using medical experts.

The Health Care Mess - Medical Society Responsibility

The American College of Physicians (ACP) recently presented an elegant model of primary care in the Annals of Internal Medicine. (1) They also made other suggestions that would greatly improve health care in The United States. What they failed to do, however, is discuss why primary care is in such a shambles and what their role should be as a professional organization. Primary care is the backbone of any successful health care program. Patients and their primary care physician – what we used to call the family doctor – can build relationships that bring much better care in the long run. Why? Because the primary care physician knows the patient as a "person" not just a jumble of symptoms and diseases. That's of the utmost importance when it comes time to make decisions about care, and for a physician to use judgment about what's appropriate for a particular patient.

Approximately one-third of care is inappropriate to the tune of $600 billion dollars a year. (2) That's a lot of money that could be directed to primary care, provide universal access and make our health care system less of a burden on our economy. The ACP should take a leading role in addressing the excessive use of technology that frequently does not benefit the patient, particularly patients at the end of their lives. (3) If the primary care system was strong, there would be a vital link between the patient and the hospital that would facilitate much better decisions about what would be in the patient's best interest.

The plain fact is that hospitals and physicians make more money with expensive procedures whether they help the patient or not. A classic example is using coronary artery stents in patients in whom medications alone are equally efficacious. (5) The growth of specialty hospitals and procedureists is a result – not more physicians practicing primary care. At this time there's just not enough prestige and money in it.

Most of the overuse of technology and procedures occurs in large teaching hospitals. (4) What kind of message does this send to young physicians in training? Does it teach them to build relationships with their patients? To use

their judgment to decide what would benefit a patient the most? Or does it teach them to throw every procedure they can into the mix and bill handsomely for it?

Medicare has attempted to adequately fund primary care. However, because of the excessive funding for specialists and procedures, their efforts have failed. (6) If the American College of Physicians is serious about its goal of excellent primary care for all, then it must take an active role in promoting the appropriate use of our medical resources. Only with a return to a strong primary care system will we see good preventative care and the delivery of appropriate treatment for everyone.

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1. Public Policy Committee of the American College of Physicians, Ginsburg JA, Doherty RB, Ralston JF Jr. et al. Achieving a high-performance health care system with universal access: what the United States can learn from other countries. Annals of Internal Medicine 2008;148:55-75 (PMID 18056654)
2. Garson A Jr., Engelhard CL. Health Care Half Truths; Too Many Myths, Not Enough Reality. New York: Rowan and Littlefield; 2007, Page 17
3. Barnato AE, McClellen ME, Kagay CR, Garber AM. Trends in inpatient treatment intensity among Medicare beneficiaries at the end-of-life. Health Serv Res 2004;39:363-375 (PMID15032959)
4. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucus FL, Pinder EL. The implications of regional variations in Medicare spending, Parts I&II. Annals Intern Med 2003;138:273-298 (PMID 12585825 & 12585826)
5. Mitka M. Cardiologists get wake-up call stents. JAMA 2007;297:1967-1968 (PMID 17488954)
6. Ginsburg PB, Berenson RA. Revising Medicare's physician fee schedule – much activity, little change. N Engl J Med 2007;356:1201-1203 (PMID 17377156)

Universal Health Care: What's Wrong with This Picture?

Survey results in a recent article in the New England Journal of Medicine (1) show Democrats and Republican have very different views about our health care system. Democrats are not happy with the system and want universal coverage, even if it means more government involvement and higher spending. Republicans, on the other hand, are more satisfied with our present system and are more concerned with controlling costs. They favor private insurance solutions and tax breaks to decrease the number of uninsured people.

Both sides miss the point. The question is not how to finance our health care system. The question is why do we spend more money per person than other developed country, but still have more than 47 million people uninsured and lower life expectancies? Current health care costs are running around $2 trillion a year – about $7 thousand for every man, woman and child.

The reasons for this are not difficult to understand. Some of our excess costs are attributable to higher prices for medical goods and services and considerably higher administrative costs. But the big problem is our technological and procedural style of medicine, fostered by the reimbursement system of Medicare and other insurers. We pay for procedures and not for clear thinking. There are several reasons for this, and I'll examine each of them in detail in future posts.

1. Primary care (family doctor, general internist and pediatrician) has been under funded for decades, resulting in an acute shortage of primary care physicians. The old-fashioned doctor/patient relationship that provided critical insights into individual patient care is virtually non-existent.

2. There is no system of physician oversight in either hospitals or nursing homes to make sure that patients are receiving only beneficial care and not care that means a bigger tab to bill the insurance companies or Medicare/Medicaid, without any real advantage for the patient.

3. There are no controls on drug and medical device manufacturers in terms of research validity and funding, lobbying Congress to approve their products for Medicare/Medicaid coverage, or advertising their wares to the public.

4. End-of-life care in large teaching hospitals is more costly, yet the death rates are higher. There is more emphasis on expensive high-tech procedures, whether the patient will benefit or not.

Approximately 17% of gross domestic product now goes to health care. That's a significant drag on our economy, especially when compared to other countries. There is no question we need universal coverage, but to get it without bringing our economy to its knees we must change the way we practice medicine.

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1. Blendon RJ, Altman DE, Deane C, Benson JM, Brodie M, Buhr T. Health Care in the 2008 Presidential Primaries. *New England Journal of Medicine,* 2008;358:414-422 (PMID 18216365)

When is Consumer Health Care Choice Rational and When Does it Become Irrational?

When taking an intercontinental flight a person has many choices – which airline, where and at what time to leave. When boarding the plane she can choose to deplane at any time before the doors are closed. She can choose among many options that are offered by the cabin staff. When technical issues arise however, i.e. when flying through a storm, the pilot is expected to choose the correct option for safely completing the flight. Why in this situation is it the pilot and not the passenger who makes the choice? This is because the complexities involved are quite sophisticated, requiring years of training and experience.

The situation is similar in health care; the patient has many choices in many situations. The patient can choose a physician, primary care or specialist, who appears knowledgeable and caring and has a personality in tune with that of the patient. Patients can choose to be compliant and learn as much as possible about their medical situation. The patient can always choose to refuse any or all treatments. The reality is when accepting treatment for a complex situation like the airline passenger flying through a storm, the expert, in this case the physician, is in the best position to chart the course.

One of the major problems in today's medicine is that frequently even in very technical situations the patient/family is given the responsibility to determine the appropriate action. Sometimes patients are given options which they are not trained to understand and sometimes the choices contain options that are inappropriate in light of the patient's overall condition. In other instances patients/families wish to receive treatments that are also inappropriate because of the patient's medical condition. These too should not be offered. The problem is an unrealistic sense of patient autonomy which is among the major reasons why our health care is so outrageously expensive. To deal with this problem and avoid irrational care I have suggested a team of other professionals to assist the physician and patient to choose among beneficial treatment/s.

During the current health care debate many noted experts have suggested several reasonable reforms. They have mainly focused on changes in the payment system and some have suggested reforming medical malpractice laws; however, missing from the present discussion is the much needed change in the way we practice medicine. Until we as a society are willing to create a mechanism to clarify the role of patient choice and physician responsibility, successful health care reform will elude us.

The Health Care Crisis: Lack of Resources or Sick Medical Culture?

Health care in the U. S. consumes 17% of gross domestic product (GDP). That's $7000/person - about one and one-half times more than the next most expensive nation (Switzerland). Costly health care means costly health care insurance. Businesses that provide health insurance for their employees make up for the ever-rising costs by raising the price of goods and services and laying off workers. We lose jobs and lose our competitive edge in global markets. Those people not covered by employers or those out of work drop their insurance because they simply can't afford it. That means more and more people added to the tens of millions already without insurance or who are grossly under-insured. And for all that high-cost medical care, our health outcomes in many categories are dismally inferior to other industrialized nations. That is definitely not a good return on the investment!

So, who is responsible for health care delivery? Who decides what procedures and treatments will be done? These decisions play an enormous role in health care costs. In the September 24, 2009 issue of the New England Journal of Medicine, the former editor of that journal, Dr. Arnold S. Relman, writes:
"Doctors, in consultation with their patients – not insurance companies, legislators, or government officials – make most of the decisions to use medical resources, thereby determining what the Unites States spends on health care".

This being the case, why are doctors spending so much with such unacceptable results? Multiple sources suggest that about one-third of all health care spending is non-beneficial. Presently doctors deliver disjointed, overly technological, irrational care for several reasons.

1. As documented by the Dartmouth Atlas of Health Care, our major teaching centers, where costs for the same diseases vary from center to center, emphasize specialists delivering expensive technology while de-emphasizing history taking, physical exam and wise use of resources. This has taken place in large part, because Medicare reimbursement emphasizes technology rather than thinking.

2. We have a critical shortage of primary care doctors. This is largely a result of Medicare payment policies. Primary care doctors earn significantly less than specialists while having to see 30-40 patients per day. This makes a meaningful patient-doctor relationship virtually impossible and keeps young doctors from entering primary care.

3. The public is overly demanding and confused because of drug and device advertising and the recent over-emphasis on patient autonomy. They often demand procedures or treatments that are costly, but non-beneficial, and doctors are reluctant to refuse for fear of malpractice suits.

The Massachusetts universal health care experiment is a shining example of what can happen when you throw money at symptoms (millions uninsured) without treating the disease (lack of effective physician oversight). This state now has big problems with access and high costs causing extreme budgetary distress. Sadly, Capitol Hill is headed down the same road.

Part B: Problems with Today's Solutions

The Health Care Debate: the Best and Worst of Our Political Culture

We see unfolding before us the present day political process, trying on the one hand to better our society while at the same time paying off multiple parties to make it happen. The paying off does not stop at the federal trough; it also involves huge amounts of monies paid to various legislator's campaign funds to secure a favorable outcome for those special interests.

First the good:

1. Many decent hard working people are without health insurance which if illness strikes causes extreme financial and emotional hardship along with delays in obtaining care. Any thoughtful society would want to rectify this situation.

2. We as a nation spend much more per person for health care ($7,000 for every woman, man and child) than any other country yet have multiple millions uninsured with comparatively poor outcomes. Additionally our excessive share of gross domestic product devoted to health care (presently 17%) compared to other nations has caused us to loose global market share causing the loss of high paying manufacturing jobs along with decreased take home pay. There is no doubt that our high health care costs must be addressed.

Now a few examples of the bad:

1. The organized medical community, instead of taking any responsibility for the way physicians practice today with excessive reliance on technology while de-emphasizing history taking, physical diagnostic skills and integrative thinking, support health care reform as long as across the board physician payments are not curtailed. As of now, to decrease Medicare costs every year Congress threatens to make across the board decreases in doctor reimbursement. Every year the medical establishment lobbies against these cuts and in the eleventh hour they are postponed to the following year. Now to gain medical society endorsement the

administration has proposed to eliminate this yearly struggle and not decrease doctor reimbursement with the result being medical society support for passage of health care reform. Instead these societies should be offering to seek a mechanism to decrease/eliminate non-beneficial care (now totaling about $700 billion/year) and maintain reimbursement for appropriate care. The idea is that people are not widgets and need evidence based care individualized for every situation. Tailoring the right care for every person should be the mantra for physician societies.

2. We are witnessing a Congressional lobbying bonanza. The New York Times (August 2, 2009) reported that the pharmaceutical industry alone has recently spent $68 million lobbying Congress. Key legislators are having massive contributions to their re-election campaign funds. There are estimates that over 300 lobbyists are at work costing various stake-holders millions per day.

We need oversight in our medical system, not by third party payers, not by accountants, not by government, but by senior medical personnel reviewing cases, resolving conflicts and insulating physicians from the threat of legal action.

We need medical system reform that will immediately decrease costs by eliminating non-beneficial care while providing the framework for delivering excellent care at a reasonable cost regardless of how physicians are reimbursed. We need health care reform that serves our nation and not designed to serve those who lobby the most.

The Healthcare Crisis: Can We Avoid Rationing?

As healthcare costs continue to spiral out of control, the buzz is already starting about having to ration healthcare in the future. It would boil down to providing care to those who would most benefit from it. But shouldn't it be the other way around? That is – providing **only** beneficial care to every patient and not pulling every expensive technological and procedural rabbit out of the hat in cases where the outcome is basically hopeless.

So what's the answer? ***Appropriate Care Committees***. Can Appropriate Care Committees avoid the specter of healthcare rationing? My answer is a resounding yes! Let's take a look at a few of the things behind the explosion in healthcare costs.

Medicare alone is now spending over $400 billion a year, with expenses growing at an alarming rate. Congress and the President are dismayed, but haven't come up with a plan to prevent the impending financial disaster. One expert after another has said that inappropriate care is the biggest culprit in out-of-control costs - estimated at about $600 billion per year. Medicare is a large source of this problem.

So, how did all this come about. The causes are many and complex. Here are just a few.

- More and more use of expensive technology without evidence of superiority over existing methods takes advantage of lucrative quirks in the Medicare payment schedule. Some examples are proton accelerators for prostate cancer or the use of cardiac stents in patients whose conditions are just as easily managed with medication.

- Device and drug company advertising directly to the public helps promote an increasing sense of consumerism. Patients and their families have a virtual smorgasbord of drugs, devices, and procedures – all attractively packaged in the ads - that they can demand whether they'd be of any

benefit or not. And, unfortunately, many physicians are loathe to say no to them.

- Medicare's chronic under-funding of primary care and over-funding of specialists and sub-specialists who perform many unnecessary procedures plays the largest role. The under-funding of primary care has nearly destroyed the old fashioned doctor-patient relationship, so there is a marked decrease in preventative care and poor management of the chronically ill.

- Medicare, in its attempt to save money, under-funds regular hospital bed care causing hospitals to emphasize expensive intensive care units and procedures which results in spending even more dollars.

- Medical societies have been reluctant or unable to enter national dialogues about important medical issues (like the Terry Schiavo case) or help set up a support system for practitioners who wish to practice high quality appropriate medicine but are afraid of lawsuits.

So here we are. Our healthcare system consumes over 17% of the gross domestic product, we spend more per person on healthcare than any other country in the world, but with worse health outcomes, and still have more than 47 million people uninsured.

What will the government do if these runaway costs are not controlled and bring our national economy to the breaking point? Enter talk of rationing. Make no mistake. It's a very real possibility.

How can we avoid rationing and maintain the ability to individualize every case? Appropriate Care Committees - system of committees on the national, state and local levels, created by Congress with the power of law behind them. These independently funded committees of physicians, nurses, and clergy would function to review various cases in hospitals and nursing homes to insure appropriate care and would have the power to withhold funding for inappropriate

care. It wouldn't take long for the word to get out that inappropriate care is no longer a cash cow and the tangled billion-dollar web of who-does-what-and-why would quickly unravel and healthcare costs would plummet.

This system would also give the patient the benefit of an impartial opinion regarding appropriateness without any conflicts of interest since they would have no monetary or loyalty connections to a hospital, nursing home or physician. For the same reasons, they would provide support to physicians who want to provide appropriate care, but the patient or the families are demanding something else.

The cost saving of this system, along with changes in administrative structure, could well head off the looming financial crisis that could lead to healthcare rationing.

Is it Insurance Reform or Health Care Reform that should be the Focus in Washington?

Certainly insurance companies are not saints, but are they the root of the problem? Is it the insurance companies that spend $7,000 on every American for health care every year? Or rather is the underlying problem the various factors that have driven our practice towards an overly technological, less personal, less coordinated, specialty-oriented style of Medicine?

Review of The Dartmouth Atlas of Health Care sadly demonstrates that even our great teaching centers are practicing a wasteful and, in many cases, a non-beneficial style of care. No wonder that our trainees now do the same.

We must adequately reimburse primary care, practice and teach excellent history taking and physical exam skills, conceptual thinking, and most importantly, physicians must unite behind a system of peer review to ensure beneficial care and support each other to beat back the lawyers.

The Mayo Clinic: A Model for Appropriate Care But Can It Survive As Such?

I believe that a recent Time Magazine article (June 29, 2009) written by Michael Grunwald about health care conveys some truths about our health care system. Mr. Grunwald cites the Mayo Clinic as an example of how very high quality medicine can be delivered at a fraction of the costs compared to other referral centers. I agree with his assessment. Quoting from the article, "Last year, Mayo lost $840 million on $1.7 billion in Medicare work". It compensated by charging private insurers a premium for the Mayo name, but they're starting to balk. "The system pays more money for worse care," says Mayo CEO Denis Cortese. "If it doesn't start paying for value instead of volume, it will destroy the culture of the organizations with the best care. We might have to start doing more procedures just to stay in business".

There are some real insights conveyed in these few sentences. One, medicine is primarily the art of using available knowledge and science applied individually to each patient. Every patient is unique with individual characteristics and needs. A thoughtful physician must take into consideration many factors in suggesting the proper therapy for each patient. This kind of medicine is presently practiced at the Mayo Clinic without the additional billions of dollars touted as the cure-all by our political leaders and various pundits. If a physician cannot think conceptually about patients taking into consideration the entire clinical picture all the billions spent on comparative research will not be of value and will not help. Obviously at this time The Mayo Clinic does not need this additional research.

The second point, just imagine losing $840 million on $1.7 billion in Medicare activity and feeling the need to become another procedure mill to stay afloat. Why is it that the Medicare payment system, a government program, financially punishes the good players and rewards the bad? And would not the number one business of government in the Medicare program be to develop a system of care delivery that emphasizes patient by patient decision making (see appropriate care committees) to replicate the present Mayo model? The answer I believe is that our leaders in Washington look at problems globally and not as the accumulation

of millions of individual events. Governments need to count widgets to justify payment and do not know how to account for the intangibles like thinking, individuality and human trust. The result is an overabundance of quantifiable widgets at great excess costs and a diminution of value in thinking, communication and personnel satisfaction.

Although during the present discussion about health care reform one hears about paying for outcomes, we hear more about Medicare cuts in reimbursement to hospitals and physicians. But, these proposed cuts are global and not based on the individual needs of each patient. This is especially unfortunate because if we could inject the wisdom displayed by the Mayo Clinic into all of our health care there would be more than enough resources to provide universal coverage. And this would be accomplished at a decreased percentage of gross domestic product devoted to health care rather than the increases intrinsic to the present proposals.

Is Fee-For-Service the Reason for Our Excessive Health Care Spending?

The evidence is overwhelming that we, as a nation, do not practice efficient medicine. We spend about twice as much per person as any other country yet have many millions without adequate health care. It is becoming obvious that physician practices are a major component of this excess spending. Many experts refer to the non fee-for-service centers such as The Mayo Clinic, The Cleveland Clinic, The Geisinger Clinic and others as examples of efficiency and state that fee-for-service medicine is the major driving force for our excessively expensive medical care.

I do not doubt that fee-for-service is a component of this problem, but are there other factors that are equally if not more important? After all, The Dartmouth Atlas of Health Care has demonstrated that many areas with large university medical centers with medical staffs on salary spend much larger amounts for the same conditions than the most efficient centers. And where are the big physician profits in medicine, in professional fees, i.e. Medicare part B or in facility fees, i.e. Medicare part A? There is no doubt that the big profits come from ownership and not professional fees. Thus many question the propriety of physicians profiting from facilities to which they refer patients. This has nothing to do with fee-for-service. Other factors include:

1. The mistaken belief by many that limiting non-beneficial care is rationing.

2. A fascination for glitzy buildings and fancy machines, leading to real excess.

3. Public demand heightened by drug and device advertising via the mass media.

4. A Medicare payment system that emphasizes expensive machinery at the expense of person to person patient-physician time.

5. Organized medicine's inability to articulate to the public:

a) what is rational health care?
b) the importance of history and physical diagnostic skills of physicians, skills that are now being de-emphasized in favor of various expensive tests.
c) lack of a concerted effort to promote a more equitable and realistic tort system.

Thus, although fee-for-service may entice some, if not many, physicians to do something extra, it is only part of a much more complex problem. The culture of intensive peer review at The Mayo Clinic and the other efficient medical centers may indeed be the secret of their success, rather than the lack of fee-for-service.

Medicare - America's Single Payer Healthcare System

Medicare is the single payer system for the approximately 44 million eligible citizens who are 65 years and older. Passed by Congress and signed into law by President Lyndon Johnson in July 1965, it is now in deep financial trouble. This is despite its low administrative overhead which is the proposed great advantage of a single payer system. The lesson to be learned by this experience is that low overhead alone does not guarantee adequate funding if the fundamental flaws in the health care system are not addressed.

There are two fundamental flaws perpetuated by Medicare that have so far escaped correction - the under funding of primary care and the lack of a system to prevent inappropriate care.

1. Since its inception Medicare has under-funded primary care, which has led to the continuous and progressive decline of this specialty. Starting in 1965 Medicare paid what were then the usual and customary fees for physician services. This payment formula emphasized technology and procedures while underpaying primary care. An attempt was made to correct this imbalance by instituting the Resource Based Value System in 1992. This process has also failed to adequately reimburse primary care. The result has been the continued declines of the number of physicians practicing this specialty along with shortened visits and decreased in-hospital follow up. The shortage of primary care physicians has also led to inadequate preventative care for our population. Many authors have stated that if universal coverage would somehow appear tomorrow, with the deplorable state of primary care which is the infrastructure of any nation's medical system, the health of the nation would not improve. We must correct the inadequate reimbursement for primary care.

2. There is no oversight to prevent non-beneficial care. Such unnecessary care consumes approximately one third of Medicare's budget which translated to our entire medical system equals six hundred billion dollars yearly! See my previous posting on why we need Appropriate Care Committees.

Nothing New Under the Sun: Massachusetts All Over Again

A law signed in April 2006 in Massachusetts created state funded health care for all of its citizens. There was a deliberate decision to first insure the entire population and then once this was established deal with the cost issue. The idea was to offend no one, keep every constituency happy. Then sometime in the future face the music when costs become unbearable.

False arguments were made such as, universal coverage should in of itself lower costs by preventing chronic disease. This is of course absurd; chronic disease is frequently a product of medical care, keeping people alive who years ago would have died because of their illness. As average life span increases, the chronic disease burden increases and so does the cost. Another false argument was that with insurance for all emergency room visits with their large expense would be drastically reduced. But, that has not happened because of the severe shortage in Massachusetts of primary care physicians. Thus when people become ill their only alternative is the emergency room. There was no provision in the Massachusetts law regarding inappropriate non-beneficial care. However, one only has to look at the Dartmouth Atlas of Health Care to see that a large proportion of care in the state is inappropriate and extremely expensive.

So now Massachusetts has a financial crisis that must be addressed and unlike the federal government cannot print money to cover its costs. Will universal coverage in the state survive? Only time will tell.

The news from Washington is:

1. Medicare is facing insolvency in 2017, if changes are not made.
2. Many working families and our industries are now in financial distress because of the escalating costs of health insurance.
3. There is great variation in the Medicare cost of hospitalization throughout the country without commensurate benefits.

But what of the solutions offered – pabulum disguised as reform that does not address the causes of our excessively expensive health care – Massachusetts revisited!

1. A White House conference including representatives of the health industry that makes vague promises to decrease the increase in administrative costs over the long term. No mention of tackling the problem causing excessive administrative costs at this time.

2. Electronic medical records, a good idea for patient care but not a cost saver.

3. A Comparative Effectiveness Institute, a bad idea that also is not a cost saver.

4. Enhanced wellness – a vague idea involving dramatic changes in life style of most of our citizens – probably not to be seen in our life time.

5. A change in incentives so that doctors will be encouraged to deliver high quality care. A vague concept that sounds good, but says little.

David Brooks in an op-ed piece in the Wall Street Journal (May 15), titled his piece, Fiscal Suicide Ahead, in essence saying the proposed health care cost savings so far considered by the Administration and Congress maybe good ideas, but will not decrease costs. Thus the funds for the entire Obama agenda will not be available with the result being gross overspending and excessive debt.

By not addressing the fundamental problems within our health care system at this time, and maintaining these very excessive costs, the federal government will find itself in a predicament that makes Massachusetts look reasonable.

Questionable Funding of Universal Coverage

Our political leaders tell us that, in the past, there have been no decreases in services after cuts in Medicare funding. Therefore, it is reasonable to fund a portion of the costs of universal coverage with further cuts in Medicare reimbursement rates.

It is true that most Medicare beneficiaries are pleased with the program despite the decreases in payment rates over the years (for an excellent short review of Medicare's payment history (http://www.hlc.org/medicare_history_memo.pdf). Despite these decreases in payment for each service, total Medicare expenditures and share of the federal budget are increasing. But in reality, how is Medicare actually funded and have these decreases caused a dramatic change in the practice of medicine in this country?

Although Medicare makes up about one sixth of our total national health care spending, it is the largest insurer and has a major impact on the allocation of health care resources. Last year The Mayo Clinic billed Medicare $1.7 billion for medical services; however, they lost $840 million due to Medicare underpayment. They made up for this loss by overcharging private insurance, i.e. cross-subsidization. The Mayo Clinic is not alone in this practice. Every hospital in the country has to do the same. Thus the working public has been paying more for their health insurance to offset the inadequate payments that Congress has allotted for Medicare - in essence, a hidden tax on workers.

Hospitals and doctors also quickly learned that Medicare is relatively generous in paying for technology rather than primary care, history taking, physical diagnostic skills, cognitive and conceptual thinking. Technologies and organizations with the greatest lobbying budgets have received the lion's share of reimbursement. As a result we have an undersupply of primary care doctors, an oversupply of procedureists, an emphasis on intensive care units, overuse of cardiac catheritization and stenting, a frenzy of building proton accelerators and the list goes on and on. With further cuts in Medicare reimbursement to help pay for universal coverage without real structural changes on how we practice medicine,

cross-subsidization from private insurance and even a greater emphasis on the overuse of procedures and technology will most likely occur.

Instead of delving into these and other reasons as to why we spend much more than any other country on health care, Washington is again trying the already failed economic approach of decreasing payments. Multiple experts using different methods demonstrated that we spend about $700 billion dollars yearly on non-beneficial inappropriate care. Physicians working together as part of intensive peer review could address this overspending at the physician-patient interface, thus ensuring individualized evidence-based beneficial care. I believe the economic approach now being pursued by our political leaders will prove to be more frustrating and in the end more expensive. It is time to put the responsibility for rational beneficial care where it should be - on physicians.

The Election is Over, the Health Care Crisis Still Looms, So Now What?

As the national election drew near, a spate of Perspective articles in the New England Journal of Medicine discussed the problems and possible solutions to providing universal health care coverage. Most begin with the now familiar litany of problems with our present system: greater percentage of gross domestic product (GDP) spent on health care than any other nation yet millions are under and uninsured, poor results when compared to other nations, and an economic burden that is costing jobs while lowering the standard of living of the middle class.

The first four papers were from each of the presidential campaigns and then a rebuttal. The Obama campaign identified many of the problems in our system. Although the excessive costs of our present practice of medicine were discussed, the solutions were superficial and vague. While more uninsured would be covered, the anticipated increase in spending would make these reforms unattainable or so expensive as to cause more chaos to our economy. The McCain campaign, although recognizing many of the American people's concerns, offered a solution that is primarily a change in payment scheme. Again the fundamental problems existent with our health care system were not addressed; instead the plan relied on patient dollars to create a savvy consumer able to wisely purchase services, although they are extremely complex with consumerism a major problem driving up costs. The Obama campaign countered the McCain plan as completely unrealistic and probably causing more harm than good. The McCain campaign responded to the Obama plan as unrealistic and, if enacted, prohibitively expensive. In my opinion both rebuttals were correct.

Following these exchanges, three health policy experts wrote about their ideas for changing the health care system. They argued for control of the growth of health care spending without which any attempt at universal coverage will fail. They stated that a large reason for the increase in costs is new technology and drugs. To deal with this problem they support the creation of an independent well-funded organization fashioned after the British National Institute for Health and Clinical Excellence.

I disagree with this idea for several reasons:

1. We already have a well-funded entity with known scientific excellence – The National Institutes of Health (NIH).
2. Drug and device companies now fund a great deal of research for use in clinical practice, which we know is frequently biased. Therefore, I suggest that Congress enacts legislation requiring all drug and device clinical research monies spent by the companies go through the NIH for experimental design, execution and reporting. This would ensure more valid data.
3. My proposal of the health care "Bank" would then enforce the concept that only therapies of benefit would be funded.
4. My appropriate care committee system would insure that these decisions are tailored to each individual's needs and not applied in an autocratic manner. These changes would be part of the medical system and thus would not require the creation of another expensive bureaucracy. The "Bank" would adequately fund and also enlist specialists to provide primary care, the backbone of any successful health care system and dramatically lacking in our country.

Unfortunately none of the articles dealt with medical advertising to the public (which should be prohibited), the growth of medical consumerism and the overuse of Cardiopulmonary Resuscitation and the flaws in Advanced Directives that have substantially increased health care costs. It seems that no one wishes to tackle our outrageous end-of-life care, the suffering it causes to patients, and its cost to our society. My hospital admission form and the appropriate care committee system would address these problems. We can provide world class care, universal coverage, decrease the percentage of GDP spent on health care and thus greatly enhance our standard of living by adopting my three major proposals (hospital admission form, appropriate care committees and the "Bank").

The Federal Urge to Spend: The Comparative Effectiveness Institute

Washington is thinking of spending tens of billions of dollars on a Comparative Effectiveness Institute, based on a concept borrowed from Great Britain (The National Institute for Health and Clinical Excellence). However Great Britain has adequate primary care. We do not. And Great Britain has put a dollar limit on a newer drug or procedure regardless of its potential for benefit for that particular individual, while the U.S. Congress has rightfully ruled that out for our citizens.

The biggest flaw in the need for the Institute is the assumption that American doctors do not know how to practice medicine that delivers value for the dollar, and that information on this subject does not now exist. This idea is categorically false! Physicians know very well from many existing studies when further critical care will not be beneficial, when cardiac catheritization and stenting is not warranted, when multiple transfers from nursing home to hospitals will not benefit the patient and so on. I am not discussing debatable situations, rather situations that are manifestly obvious.

It is not a lack of knowledge underlying the cause for all this inappropriate care. The culprits have been previously discussed on my blog, for instance: perverse financial incentives including excessive reimbursement for technology, inadequate primary care, fear of legal consequences, and lack of national medical standards. If you want to read up on it, get a copy of The Dartmouth Atlas of Health Care: Regional Disparity in Medicine.

On my blog I have proposed multiple steps to more effectively deal with these problems:

1. Through the Federal Health Care Clearing House and Bank, prospectively verify the benefit of newer therapies via funding of their confirmatory research through the National Institutes of Health before they are approved for general use. This information would be generated via well-performed excellent studies reported without bias.
2. Use of my new admitting form that clarifies that only beneficial care can be delivered.

3. Physician review through Appropriate Care Committees to guarantee as much as possible that care will be beneficial and uniform throughout the country.
4. Amendments to the Patient Self Determination Act, the Americans with Disabilities Act and the Emergency Medical and Active Labor Act to include the phrase, “within acceptable medical standards.”

We can provide universal coverage and decrease our percentage of gross domestic product devoted to health care. If other industrial nations throughout the world can it, so can we. And we can do it without spending billions to study this, that, and the other, when the information is already out there. However, the sense from Washington is that we have to spend many billions more before we can reduce spending. I completely disagree!

A congressional budget office 2008 report quoted in the April 7, 2009 Annals of Internal Medicine states that a Comparative Effectiveness Institute in the United States would reduce health care spending by less than one tenth of one percent. There is no doubt in my mind that my plan is far superior. Do you agree?

Health Care Reform: Time for American Medical Leadership to Start Thinking Ouside the Box.: Part One

A recent Perspective article in the New England Journal of Medicine raises concern that because the federal Food and Drug Administration (FDA) has approved certain drugs, citizens could not sue drug companies in state courts because of the preemption clause in the U.S. constitution which states that federal laws trump state laws. The article, Why Doctors Should Worry About Preemption, was written by three physicians on the Journal staff. Given their positions, they are among the top leaders in the medical community and exert considerable influence.

FDA approval is based on a four phase process with all information supplied by the drug company at a cost to the company of over eight hundred million dollars. There is much debate as to how to improve this process. Aside from this debate, the authors of this article support the concept that after FDA approval, state tort litigation augments drug safety and enhances consumer confidence in the safety of medications and devices.

I disagree and here's why:

1. Legal action does not address the fundamental problem of our drug/device approval process. Presently clinical research to define the efficacy and safety of these commodities are funded, designed and controlled by these companies. The cost of bringing a new drug/device to market is enormous with failure risking the viability of the company. As has been repeatedly shown in the recent past this research is tainted by inappropriate design, withholding of results, and conflicts of interest.

2. Patients have confidence in drugs and devices when prescribed by their physicians even though the safety and efficacy may be proven otherwise somewhere down the road. It takes many years before tort cases reach any helpful conclusion and, by that time, many patients may have been harmed.

3. Allowing drug/devise direct marketing to the public has distorted the public's view of the safety and efficacy of these products, while considerably increasing their cost.

A possible solution to this litany of problems is to have all drug and device clinical research funded by the companies, but through the National Institutes of Health (NIH). This would ensure rigorous design, honest and timely reporting of results. We might then have more high quality information disseminated to the medical community. People with conflicts of interest at the NIH would be excluded from this activity.

Funding by the companies would also be mandated to include follow-up of all products to spot any problems that occur once the drug is available to the mass market. If problems do occur or efficacy is not proven, the FDA could immediately withdraw the product from the market.

Using this system, knowledge from rigorous scientific processes would drive the system, rather than a drawn-out legal process that also has the potential for emotional misadventure, as occurred with the silicon breast implant litigation. I also propose the discontinuance of direct advertising to the public that creates excess demand for newer more expensive products that may have no benefit over older off-patent material.

It is my hope that the leadership of the prestigious New England Journal of Medicine will expand the scope of their view to consider fundamental change to the oversight of this industry rather than a slow, extremely expensive and some times grossly inappropriate legal system. We must use knowledge and science to better treat our patients, not the courtroom.

Health Care Reform: Time for American Medical Leadership to Start Thinking Outside the Box: Part Two

Now we'll look at another Perspective article in the New England Journal of Medicine, titled Collective Accountability for Medical Care – Toward Bundled Medicare Payments. It was written by senior members of The Medicare Payment Advisory Commission (Medpac).

Let's be clear upfront that Medicare's underpayment of primary care services has had a devastating effect on the supply of primary care physicians and their services over the past 43 years. The family doctor is disappearing. Only a third of all U.S. physicians are primary care doctors - the reverse ratio of all other countries that spend much less on health care than we do but have far superior results.

The article is a well-written scholarly discussion of a proposal to bundle hospital and physician services for each admission. The authors correctly state that Medicare spending is excessive and unstable and is far from delivering value for the dollar. However, the authors do not address Medpac's role in causing this situation. They claim that the incentives in a fee-for-service system are the root cause of this problem. Their solution is a bundled payment system, where Medicare would pay a consortium of hospital and physicians a fixed amount for 30 days of care for each hospitalization. The goal of this proposal would be to better coordinate hospital and later outpatient care.

As I see it, this proposal has two major flaws:

1. It in no way addresses inappropriate care. Should the patient have been admitted to the hospital in first place and were the services in the hospital appropriate considering the patient's overall condition? Inappropriate care accounts for about a third of all administered care in the U.S.

2. There is no mention of the critical importance of the primary care physician and the significant adjustments to their reimbursement so that they can spend a minimum of thirty minutes with their patients at each visit and be able to follow their patients once they are admitted to the hospital. However, in Medpac's submission to Congress in which it discussed bundling of care, an increase to primary care providers was suggested. This increase would be accomplished by an adjustment to the complex formula now being used to insure budget neutrality. When attempted in the past within the present system, this approach has proven inadequate.

Although in the Congressional report it was mentioned that many specialists do provide some primary care services, there was no mention of how dramatic the undersupply of primary care physicians is, nor of their vital role in chronic disease management. There was also no mention that it will take years of significant payment increases to rectify this shortage.

In my opinion, the answer to this problem at this time is to have internal medicine sub-specialists who are consulting on the patient's major medical problem assume primary care responsibility for that patient if the patient has no primary care doctor. They would be reimbursed at the new higher primary care rates, but not the much higher subspecialty procedural rates for those primary care services.

I believe it is time for Medpac and Congress to admit the obvious-the present system is irrevocably broken and should be replaced with a Federal Reserve type Health Care Bank. The Bank, with expert advice, would adjust physician payments to adequately fund primary care as its first priority, then fund subspecialty and procedural care. This difficult task should take place without political interference. That would be thinking outside the box.

When will we face the real issues?

An obsession with technology coupled with consumerism has led to the excesses so evident in today's practice of medicine. An excellent example was recently published by F. Knauf and P.S. Aronson, ESRD As a Window into America's Cost Crisis in Health Care, Journal American Society of Nephrology 2009; 20:2093-7, which describes how nephrology (kidney) treatments are now being applied far in excess of the original indications.

Kidney dialysis and transplantation first became available in the early 1960s. Because of cost, most people were excluded from these life saving benefits. To meet this public need, the Bureau of the Budget created a committee headed by the highly regarded nephrologist, Carl Gottschalk. This committee submitted their report in 1967 calling for federal funding to make dialysis and transplantation available through Medicare to all Americans. In 1972 this concept was approved by Congress.

The Gottschalk committee proposed that dialysis would be limited to otherwise healthy people mostly under the age of 54 years. Thus it was anticipated that dialysis or transplantation would be appropriate in 1 of 5 patients with ESRD (end stage renal disease). Maintaining these criteria would add about 40 patients/million population to the dialysis and transplantation cohort yearly. But now that number is about 400/million, with patients over the age of 75 the fastest growing sub-group, most with serious co-existing diseases causing an increase in patient suffering, hospitalization rates, and a dramatic increase in costs.

Is this good medicine? Does this liberalization of criteria lead to better medical care? Data clearly demonstrate that older patients who are non-ambulatory or with other co-morbidities frequently die in the hospital rather than in the community while receiving little or no benefit. Another recent paper in the New England Journal of Medicine, 2009:361; 1539-1547, demonstrated that nursing home patients, after one year on dialysis, have a death rate of 58 percent and a significant decrease in an already limited functional status. Instead of the careful

and thoughtful use of technology mixed with insight and compassion, we in America seek an inappropriate technological solution no matter how great the evidence that it will not be beneficial. Thus, the only pathway to successful health care reform is to develop mechanisms to alter the present medical culture. The approach should be based on the individual characteristics and needs of each patient.

Unfortunately the present plans for health care reform do not in any way address these basic problems. As stated in a recent (Nov. 16, 2009) op-ed essay in the Washington Post by Robert J. Samuelson,

There is an air of absurdity to what is mistakenly called "health-care reform". Everyone knows that the United States faces massive governmental budget deficits as far as calculators can project, driven heavily by an aging population and uncontrolled health costs. As we recover slowly from a devastating recession, it's widely agreed that, though deficits should not be cut abruptly (lest the economy resume its slump), a prudent society would embark on long-term policies to control health costs, reduce government spending and curb massive future deficits. The administration estimates these at $9 trillion from 2010 to 2019. The president and all his top economic advisers proclaim the same cautionary message. So what do they do? Just the opposite. Their far-reaching overhaul of the health-care system -- which Congress is halfway toward enacting -- would almost certainly make matters worse. It would create new, open-ended medical entitlements that threaten higher deficits and would do little to suppress surging health costs. The disconnect between what President Obama says and what he's doing is so glaring that most people could not abide it. The president, his advisers and allies have no trouble. But reconciling blatantly contradictory objectives requires them to engage in willful self-deception, public dishonesty, or both.

There is no doubt that this country needs health care reform that addresses our aberrant medical culture. There certainly is no sign of that at this time.

Part C: How to Fix Our Health Care System

A New Style of Hospital Admission Form

There are many reasons why our American health care system is so much more expensive than those in other developed countries, and yet we have inferior results. But, by far the largest single reason is the delivery of non-beneficial care which accounts for about one third of our total health care bill and contributes to a tremendous amount of unnecessary human suffering. Perhaps the most obvious example of our inappropriate care is the prolonged anguish and cost associated with the way we practice end-of-life care. Unfortunately however, the irrationality of how we practice medicine in the United States is not isolated to end of life care. Issues that must be addressed are:

- How can we create an advance directive that is both up to date and rational considering the over-all condition of the individual?
- How can we ensure that the care being given is beneficial and not serving other masters such as cash flow, avoiding legal hassles, the prestige of the hospital, etc.?
- How can we make sure that every patient and family has the right to appeal the medical team's decision as to what is beneficial?
- How are we to avoid doing cardiopulmonary resuscitation on patients that are far too frail to benefit and who as a result suffer a disfiguring inhumane death?

The answer to these questions is my proposed hospital admission form shown below. The form provides a realistic up-to-the-moment advanced directive while providing an opportunity for the patient/family and the medical team to agree on what will be beneficial care. It also provides the patient/family and the medical team a mechanism to resolve disagreements, the appropriate care committee. This new admission form would also make cardiopulmonary resuscitation an ordered event for those patients who could benefit from it in any way, and not done routinely for the majority of patients for which it is of no value.

New Hospital Admission Form

Appropriate Care Hospital Admission Form

Name _____ Med. Record #_____
D.O.B. _____ Date _____

1. Is Patient capable of decision making: Yes ( ) No ( )
   If No, who is responsible? Next of Kin/ guardian: _____
   phone_____

2. Cardiopulmonary Resuscitation (CPR) is ordered on this patient: Yes ( ) No ( )

   Place the following restrictions on CPR. DO NOT DO THE FOLLOWING:
   ( ) intubation ( ) chest compression ( ) resuscitation drugs ( ) cardioversion

3. When thought to be in an end of life situation by the medical team, I want to receive palliative care and consider placement in hospice: Yes ( ) No ( )
   If No, the appropriate care I want is: _____

6. Other therapies this patient has chosen to refuse even though medically indicated are:

5. Other Stipulations or Concerns:

This form serves as a guide for physicians to carry out the wishes of the patient. There is a hospital physician team responsible for oversight of appropriate care, whose goal is to help define beneficial care appropriate for the patient (the benefit to the patient significantly exceeds the risks). An expanded peer review care committee is available for the patient should conflict arise.

Physician Signature _____
Patient Signature _____
Witness Signature _____

How to Change a Health Care Culture of Excess

We have seen great strides in the decrease of deaths caused by heart disease in the past few decades - better control of elevated blood pressure, still far from ideal, drugs to lower cholesterol and procedures to improve ischemic (not enough blood flow) heart disease.

One of the procedures, cardiac catheritization and stenting, is provided for about a million patients each year at a cost of roughly $60 billion. The question that has recently been posed is what patients should receive this procedure? The answer, it turns out, is that the procedure should be limited to those with very severe angina (chest pain due to ischemic heart disease), and those with increasing or unstable angina. Drugs alone are quite adequate for the majority of patients who have stable and milder angina.

As a matter of fact, a cardiologist from Miami, Dr. Michael Ozner, has recently published a book, The Great American Heart Hoax, decrying the approximately sixty billion dollar expenditure via overuse of cardiac catheritization and stenting. The science behind the concept that treating the lesions seen on an angiogram is in most cases folly is well documented and accepted by leaders in the field. In spite of this, by far the majority of patients receiving this procedure are in the non-indicated group. Of course cardiology is not the only specialty of excess. Many, if not a majority of medical areas such as end-of-life care, dialysis, orthopedics, oncology etc., combine to create a medical system of inappropriate care with a whopping $600 billion price tag.

Any solution to this problem must be timely, combining medical knowledge with excellent judgment while treating each patient as an individual. This is a task for my local appropriate care committee, salaried and made up of two physicians and a nurse.

For instance: the committee in each hospital would review 50 to 100 charts of patients who had recently undergone catheritization and stenting. Those determined to be unnecessary would require the physicians and the facility

(hospital or clinic) to reimburse the third-party payers for these services. This would at the outset require the return of significant amounts of money. This process would be repeated in many areas such as the intensive care units, dialysis, oncology units, etc. The physicians and hospital administrators would quickly learn that inappropriate care is not a good idea. The culture would change overnight and we would have a different medical system.

Monies saved would be more than adequate to properly reimburse primary care and provide universal coverage. No system of saving can be perfect. However, I believe that of the $600 billion spent on inappropriate care, we could save approximately $400 billion. The process would be especially sensitive that any and all care from which a patient could benefit would be encouraged.

Steps to Affordable Universal Coverage

As we pursue universal coverage there are some realities to contemplate as we try to provide *affordable* universal coverage.

1. The U.S., at this time, does not have an adequate health care workforce to deliver excellent universal coverage no matter how much money is spent.

    a) The nursing shortage in the United States is acute and getting worse! If one looks at the workforce as a pyramid with nurses at the base, physician assistants/ nurse practitioners as a next layer and physicians at the top, we have a grossly inadequate base. We have to dramatically increase the number of our citizens pursuing a career in nursing.

    b) The physician workforce in the United States is woefully lacking in primary care, with now only 1/3 of physicians practicing primary care and 2/3 functioning as specialists. This is an inverse ratio from other developed nations which have much better health care results. Without adequate primary care, chronic conditions cannot be adequately cared for and preventative medicine cannot be delivered. Medicare and its payment system have emphasized procedural and technological medicine which has decimated primary care. Changing economic factors can increase the number of medical students going into primary care but it will take decades by this alone to reverse the aberrant ratio of primary care to specialist doctors. Thus a system is needed at this time so that many of our specialists also practice primary care.

2. We need to change our views about medical care in this country

    a) Commercialization – Medicine is not a commercial product. Rather, medicine is a personal experience between an individual patient, each with her/his uniqueness, and a knowledgeable, empathetic, caring physician who has the judgment to be able to meet each patient's individual needs. Specialists, computerization, modern drugs, devices

and procedures are useful when appropriate, but harmful when overused. The overuse of medical facilities, documented by the variability in the cost of care from one area of the nation to another, is in part an unfortunate result of commercialization. Direct to the consumer drug, device and hospital advertising adds to this problem. The influence medical device and drug companies have on our system is pervasive and in many instances abusive. We will have to control the excess commercialization of health care that is now present in our system to be able to provide affordable universal coverage for all our citizens.

b) Consumerism - Many experts have voiced that we, as a nation, must learn that more is not necessarily better in medicine. Yes, the newest may be the correct treatment in some circumstances, but in others the best treatment may be no treatment or an old tried-and-true therapy. The Congress, in its desire to protect the consumer, has passed laws - The Patient Self Determination Act, The Americans with Disabilities Act and The Emergency Medical Treatment & Labor Act, all written without a key phrase, for example, **within the boundaries of acceptable medical standards**. Unfortunately this oversight has hampered our legal system and promoted consumerism.

The Electronic Medical Record: Must it Cost Billions to the Tax Payer?

According to a Dow Jones article the U.S. government plans to spend 20 billion dollars in five years to achieve a 12.6 billion dollar savings in ten. It is just me, or is there something bizarre about these numbers? The expenditure estimate is from an interpretation of the latest U.S. government spending plans, the savings estimate from the Congressional Budget Office. These numbers are quite approximate and may vary, but the main point is clear: electronic medical records are a good idea for coordinating patient care, but are not a tool for significant cost savings.

Is there an alternative that will provide the benefits of the electronic medical record and not require spending billions of our government's dollars? Yes there is, with a little imagination and Congressional action. This plan calls for Congress to create a Federal Health Care Clearing House and Bank. The Bank's first function would be to create a computer based national clearing house for patients' billing and medical records. Many large information technology corporations (i.e. Google, Microsoft and others) have created comprehensive computer programs that can interact with various other hospital and outpatient data systems. The "Bank" would use standard federal government procedures for bidding and selecting the program/s and site/s for maintaining this medical record and billing system. This medical information would be kept in a central location/s with other sites for backup. The key aspect of this proposal is the centralization for maintaining electronic medical records, thus greatly lowering costs.

The central computer would receive billing and patient records from every hospital and medical entity in the land. All hospitals have most if not all their patient records on computer at this time. The "Bank" would charge the hospital, insurance companies and other medical entities a fee for each transaction. These fees would be calculated to support the computer system and would be quite modest for each entry. Keep in mind that there are millions of hospital-patient interactions and many millions of other medical transactions each year. Doctors would access the central computer, enter their information and would also be charged a much smaller fee. Pharmacy and other services would do the same.

Patients would be able to access their own medical record free of charge.

There would be multiple levels of computer security, but with an additional caveat. As access to computer records can be traced more accurately than with paper systems, violators can be determined with greater ease. Congress when creating the “Bank” would also mandate heavy fines for unauthorized access, thus helping to ensure confidentiality.

I believe this is a workable and cost saving idea. I welcome your comments about this concept.

The Problems with Advance Directives, Inappropriate Care and A Solution

Only about 20% of Americans have executed an advance directive and only about half of these have discussed their wishes with their physician. (1) Without one, most hospitals and nursing homes assume that the patient wishes every conceivable means of medical therapy, even if inappropriate for that particular patient. Another problem with advance directives is that it asks the person to make a decision about what type of care would be wanted at some time in the future. However, one could not possibly know what the clinical situation will be at that time.

My solution is a new style of hospital admission form. The advantages of this form and its benefit to patients, families and our society include:

1. This form would be completed at each hospital and nursing home admission and would serve as a fresh and timely advance directive. The patient/family can make a much more rational decision about which therapies are not wanted. Because admission to a hospital or nursing home is an extremely stressful time for the patient and family, the medical team can facilitate the completion of an up to date advanced directive with the patient/family at that time.

2. During the discussion about the form upon admission to the hospital or nursing home, the physician can clarify the fact that only beneficial care can be administered but that the patient/family retains the right to refuse any or all offered treatments (if of age and sound mind). This eliminates, as much as possible, the potential of delivering inappropriate care.

3. The form would be adopted by Congress to be used for all Medicare and Medicaid patients and would create a legal framework for the appropriate care committee system.

4. Using this form would eliminate cardiopulmonary resuscitation (CPR) by default – that is performing CPR whether it would benefit the patient or

not. CPR - the restarting of heartbeat and breathing - was first developed in the early 1960s, before Medicare, when the hospital patient population was much younger. So it was reasonable to be automatically initiated whenever there was a cardiac arrest because the patients had a more reasonable chance of survival and recovery. However, the hospital population is now much older and many are in an end-of-life situation. Despite this change in demographics the custom still remains to automatically attempt CPR, even in patients with end-stage disease despite great discomfit to the dying patient. This occurs unless a specific order is written to avoid the procedure. My proposed admission form would correct this problem by making cardiopulmonary resuscitation an ordered event to be used only in the appropriate circumstance. This would save many thousands of patients a great deal of discomfort and preserve billions of dollars of resources.

5. I have copyrighted this form so that I could insure that it be used in a constructive manner.

6. Because of the importance of this form to the reintroduction of rationality to our medical system I am asking all of you who visit my blog to download the introductory letter and the form and fax them to your Congress Person and Senators. Download the letter and the form here.

Teno J, Lynn J, Wenger N, et al. Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self Determination Act and the SUPPORT Intervention. SUPPORT Investigators Study to Understand Prognosis and Preferences for Outcomes and Risk of Treatment. Journal of the American Geriatrics Society 1997;45:500-507 (PMID 9100721)

The Road to Universal Coverage

1. The U.S. Healthcare Workforce

The U.S., at this time, does not have an adequate healthcare workforce to deliver excellent universal coverage no matter how much money is spent.

a) The nursing shortage in the United States is acute and getting worse! If one looks at the workforce as a pyramid with nurses at the base, physician extenders as a thin next layer, and physicians at the top, we have a grossly inadequate base. We have to dramatically increase the number of young Americans pursuing a career in nursing.

b) The physician workforce in the United States is woefully lacking in primary care; today, only 1/3 of physicians practice primary care and 2/3 practice as specialists. This is an inverse ratio from other developed nations with much better health care results. Without adequate primary care, chronic conditions cannot be adequately cared for and preventative medicine cannot be delivered. Medicare and its payment system have emphasized procedural and technological medicine which has decimated primary care. Changing economic factors can increase the number of medical students going into primary care, but it will take decades by this method alone to reverse the aberrant ratio of primary care to specialists doctors. We need a system in which many of our specialists also practice primary care.

2. Beneficial Care, A New Admitting Form and Appropriate Care Committees

Medical care must be of high quality and deliver value for the dollar. This means that only beneficial care can be given, using judgment on a case by case basis determined by each patient's individual overall health situation. This must be done in tandem with expanded coverage or excess costs will quickly bankrupt the system. We need to deal with consumerism and the commercialization of medicine that has become the American healthcare

system. There are many examples of excess use of technology - the Courage trial demonstrating overuse of procedures in coronary artery disease, over half a million deaths yearly in intensive care units of patients who belong in hospice, etc, etc, - that must be addressed immediately and for which ample data is presently available. If not done the percent gross domestic product (GDP) devoted to health care in the U.S. will continue to increase. The economic distortions to our economy will continue, regardless if paid for by private means or taxes. We must quickly decrease our percent GDP devoted to healthcare while providing universal coverage, which, with the proper controls (hospital admission form and appropriate care committees) can be immediately achieved, or this laudable goal will cause more economic hardship for our people.

3. A Healthcare Board (synonymous with Health Care Bank)
   This board would be fashioned after the Federal Reserve Bank taking the management but not the responsibility of healthcare out of the hands of Congress is an idea whose time has come.

Towards a Rational End-of-Life Policy

We have recently witnessed an intense controversy over end-of-life counseling. Deep inside the Congressional House Health Care Reform Bill was a section paying physicians to have end-of-life discussions with patients at least every five years. To be generous it was meant to be helpful. To be cynical it was an attempt at cost saving. Opponents to the proposed legislation exaggerated its intent using inflammatory rhetoric which made headlines but added little to nothing constructive towards a thoughtful discussion of a very sensitive topic.

The medical advancements available to maintain bodily functions (such as heart beat) beginning in the 1970's caught our entire society ill-prepared. Two famous cases illustrate this point.

1. In 1975, 21 y/o girl Karen Ann Quinlan suffered anoxic brain damage (not enough oxygen), causing irreversible and complete loss of her cerebral cortex. The cerebral cortex is the humanized part of the brain responsible for consciousness, thinking, awareness, speech, purposeful movement, and all other human traits. She was kept "alive" by artificial means. Karen's father wanted to remove a breathing machine realizing she was irretrievably lost as a person. He was vigorously opposed by her physicians, the local prosecutor and the New Jersey Attorney General. This opposition was most unfortunate considering Karen's loss of humanness. Physician opposition to removing the respirator help created the image of physicians as irrational purveyors of technology regardless of the potential for benefit. This does not absolve agents of the state who were also complicit in this irrational use of technology. It took the New Jersey Supreme Court to give the father authority to remove the respirator.

2. A similar crisis arose in 1983 when 25 y/o Nancy Cruzan also suffered anoxic brain damage and irreversible loss of her cerebral cortex because of an automobile accident. She was kept "alive" in a state hospital via artificial nutrition although her parents, realizing recovery was impossible, wanted cessation of all therapy. The conflict which arose between the state and the

parents was resolved by the U.S. Supreme Court which in 1990 ruled that a competent person could refuse artificial means to sustain her/his life. A corollary to this is that a competent patient can refuse any or all therapy. Shortly thereafter friends of Nancy testified that she would not have wished this kind of treatment. Life support was removed and she ceased to exist shortly afterwards.

Later, in 1990, Congress, as part of budget legislation, passed the Patient Self Determination Act that became the authority for states to initiate advanced directives. Missing from the act was the phrase, "Within the boundaries of good medical practice". Thus the imperative of knowing the medical feasibility of any desired treatment was missing.

There is a voice missing from this abbreviated synopsis. What is the opinion of physicians and their medical societies on this issue? Their silence was and still is deafening! Should not the fact that complete and irreversible loss of all human functions enter into the decision process, especially when there is medical certainty that for this individual there is no chance of recovery?

Unfortunately cost considerations are mentioned by some when discussing this issue. However, many more important principles are at hand.

1. It is unethical to have a human body decompose in a hospital bed with absolutely no chance of recovery in the name of medical care.

2. The doctors, doctors-in-training and nurses become desensitized to human suffering perhaps lasting their entire careers if they participate in de-humanizing non-beneficial care!

3. Training young physicians and nurses to have the skills to provide futile care takes away from learning more important humane skills such as tolerance, kindness, empathy and physician-patient communication.

4. Families while experiencing great stress are forced to make decisions regarding the continuation of care in situations where further care is only prolonging death.

5. Advanced directives created at any time in the past and without physician input as to what is feasible are at best problematic and at worse deceiving. I suggest that a new admitting form be routine at every hospitalization to determine patient desires and medical feasibility.

In summary, for this nation to develop a rational end-of-life policy it must be based on human need, realistic expectations and devoid of any financial considerations. It must be policy that if there is any chance of recovery there should be no consideration of cost.

United States (U.S.) Health Care Costs versus The United Kingdom (U.K.): What We Can Do About It

The Organization for Economic Cooperation and Development (OECD) is the body that generates comparative national data regarding health care spending. This involves the compilation of massive amounts of data, thus the comparisons are about three years behind the present date. The latest data I could find is for the year 2007. In that year the U.S. devoted 16% of gross domestic product (GDP) to health care while the U.K. devoted 8.4%. In equivalent dollars per person spending was $7290 in the U.S. and $2992 in the U.K., quite a difference. Disease adjusted mortality was then and is now superior in the U.K. than in the U.S. If I had compared the U.S. to another industrialized nation, the exact figures would be different, but the lesson is the same: the U.S. spends much more than any other nation on health care without having superior results.

These differences have been the focus of many investigations and publications. Noted experts Uwe E. Reinhardt, Gerald F. Anderson and at that time Ph.D. candidate Peter Hussey published a paper in Health Affairs 2004 examining differences in cost from an economic prospective. They focused on a number of factors, some of which cannot be changed (1-2) and others that could be addressed (3-5).

1. As nations' GDP increases, the fraction of spending on health care also increases.

2. Because of the many opportunities in our large economy we have an increased cost of recruiting and keeping talented people in medicine.

3. In our present system there is greater market power in the supply side versus the demand side for health care. This is because we have a greatly fragmented payment system.

4. Because of the greater complexity of our medical system we have significantly greater administrative costs. These two factors, 3 & 4 could be

addressed by creating a series of standardized insurance plans across the country (see link to policy paper on right hand margin- look under health care bank).

5. We have a practice of medicine that lacks discipline when weighing benefit to risk ratios, leading to much non-beneficial care along with the excessive use of technology. To address this need for a cultural change in the way we practice medicine I have suggested a timely physician and nurse support system and a dialogue between patient and physician as to what constitutes beneficial care.

Additionally, superiority in physical diagnostic skills helps explain why physicians in the U.K. rely less on expensive diagnostic testing than their colleagues in the U.S. American medical students now have to demonstrate physician diagnostic skills before graduation. This is certainly progress in the right direction, but is it enough? I think not. Presently there is not an oral exam focusing on physical diagnosis after three years of an Internal Medicine residency; hence this expertise has disappeared. Dr. Abraham Verghese, Professor of the Theory and Practice of Medicine at Stanford University, comparing the physical diagnosis training of medical students in the U.S. versus that in the U.K., stated in The American Medical Association Journal of Ethics, 2009:

I have no doubt that if we attempted to put in place a standardized test using standardized and real patients, with examiners watching for technique as well as understanding of the methods of bedside examination, our students and residents would (much as they do in Canada and Britain) spend a lot more time mastering these skills…..I have great confidence in the clinical knowledge and patient management skills of our students and residents, but the area of bedside skills is in need of improvement, particularly if we are to practice cost-effective medicine and minimize a patient's exposure to radiation. Imaging tests are valuable and often necessary, but if simple bedside skills make them unnecessary, then lack of such skills is not just costly, but dangerous.

I completely agree with Dr. Verghese. I along with most of my colleagues are

concerned that presently most our Internal Medicine residents are not skilled in excellent physical diagnostic techniques. Certainly challenging these residents to learn superior physical diagnostic skills will not completely solve our problem of an exorbitantly expensive style of medicine; however, it would be a step forward for making our medical system less technologically dependent, more rational, safer and less expensive.

What Should Be The Goal Of Health Care Reform?

Until a few months ago the cost of health care and the percent of gross domestic product it consumes was a major concern. Our goods were not competitive on the world market in large part because of health care costs, manufacturing jobs were leaving the country and the standard of living of the middle class was compromised, all in large part because of these costs. Despite these expenditures 47 million citizens are not insured and our outcomes are poor compared with those of other industrial countries. The reasons for our excessive spending, approximately twice as much per person as any other country, are well known:

1. An insufficient number of primary care physicians and an excess of specialists.
2. Over-reimbursement for technology and under-reimbursement for conceptual thinking and judgment.
3. Approximately $700 billion spent each year on inappropriate non-beneficial care driven in large part by our largest hospitals.
4. Excessive administrative costs in the private sector.

Without addressing these issues as in Massachusetts any attempt at universal coverage will face financial collapse!

Now we as a society are correctly trying to provide coverage for the entire nation, but without seriously addressing our excessive costs. Even the Congressional Budget Office has recently voiced the opinion that the cost control measures being discussed are at best speculative. Now we read that Congress is considering additional taxes that will certainly increase the gross domestic product devoted to health care. Thus our goods and services will be even less competitive in the global marketplace. With an even greater decline in our global competitiveness more high paying skilled jobs leave the country. In terms of social justice, without seriously addressing the known excessive costs in our health care system, as we spend more to provide universal coverage (increased social justice) we loose high paying skilled manufacturing jobs (decreased social justice).

The health care system in our country is incredibly complex and how to fix it seems elusive. However if one uses end-of-life care as a lens to understand the various forces that have created this massive over-spending and poor care one can then address the problems and provide better care for all at significantly less cost.

That is why after forty years of practice I choose to write my book, In Defiance of Death: Exposing the Real Costs of End of Life Care, which demonstrates the many problems inherent in our current system and proposes a set of feasible solutions. Our goal should be universal coverage with a health care system consuming about 15% of gross domestic product. By focusing on how to fix end-of-life care, establishing appropriate care committees, creating a new hospital admitting form and a Federal Health Care Bank with varied administrative functions, we can achieve this goal.

Overly High Healthcare Administrative Costs And A Solution

Billions of healthcare dollars go to paying the salaries of the folks who have to handle healthcare claims – both from insurance companies and Medicare. There are all kinds of different insurance policies with variations in coverage. That means that healthcare providers have to employ people who are skilled in the complexities of the various plans. In a primary care practice that might be 2 or 3 people, in a large hospital, dozens of people. The insurance companies and Medicare also have many people working for them to ensure payment goes only to covered services. All of that adds up to a lot of money in administrative costs on all sides.

I have a solution. I propose the creation of a separately chartered, independent federal agency – like the Federal Reserve System – that would be a central clearing house for our entire health care industry – public and private. Let's call it a "Health Bank." The Health Bank would coordinate and perform many tasks now performed by insurers and healthcare providers. It would not only simplify the system and make it more uniform, it would decrease administrative costs to the tune of billions of dollars a year. At the same time it would maintain our present mix of private and governmental insurers.

The "Bank" would:

1. convene a biannual meeting of all insurance entities to define five standardized insurance packages. The lowest cost, plan 1, would cover all essential appropriate medical services. At the other end of the scale, plan 5 would be more expensive and include extras such as podiatry, massage, health club memberships, plastic surgery, etc. Plans 2, 3&4 would be successive gradations between plans 1&5.

2. determine fees so that primary care and regular hospital and nursing home care would be adequately reimbursed, thus providing for the rebuilding of primary care. It would eliminate the need for hospitals and nursing homes

to stress often unnecessary, non-beneficial technological and procedural care to maintain solvency.

3. establish a central computer system through which all billing takes place and through which all insurers are paid. Insurers would compete by coming up with innovative preventative programs such as weight control, diabetes and blood pressure control, home health services for the elderly, etc. along with price competition for the five plans.

4. maintain an electronic medical record system for the entire nation with multi-layered safeguards to insure privacy.

5. require that all hospitals, nursing homes, other health providers and insurance entities (public and private) adjust their computer programs so that all could interface with the bank's computers.

6. fund The National Institutes of Health (our major national research endeavor) by collecting monies from all insurers, governmental and private, in proportion to the percentage of the population covered by each one. This type of research is an investment for the future and should be funded by all carriers, not just the federal government.

7. fund graduate medical education (residencies & fellowships) through funding from all carriers in proportion to their market share and make payments directly to the educational entities.

8. pay the salaries and staff of the appropriate care committee system (local, state & national).

9. require all drug and device companies to fund their clinical research through The National Institutes of Health which would oversee the experimental design and the results. This would remove the conflicts of

interest that exist in the present system. The Health Bank would collect and distribute the funds.

10. be funded by fees paid by all carriers in proportion to their market share. The Health Bank, like the Federal Reserve, would report to Congress on a fixed schedule.

More details of how the Health Bank would work and how it would facilitate universal healthcare coverage are in my book *In Defiance of Death: Exposing the Real Costs of End-of-Life Care*. You can order the book from Amazon through the link here at the blog.

Is This Appropriate Health Care? You Decide.

A 97 year old woman, while in an intensive care unit in a smaller community hospital had written, “Please let me die." Later after transfer to a larger hospital she was on life support and slowly decomposing - literally. This is an example of a modern American tragedy that happens to many thousands yearly.

Because this woman did not have an advanced directive, she was kept “alive” by a reluctant medical community under the authority of a legal guardian and a probate judge. The judge did not seek medical opinion as to the patient’s viability, chances of recovery, damage to her body that would occur as a result of the breathing & feeding tubes, irretrievable lack of consciousness and multi-organ failure. Rather, the judge chose to rule that without a properly executed advanced directive, every conceivable medical treatment must be utilized to keep her heart beating.

Wrapped in legal jargon, most would argue that this was an irrational, cruel and inhumane plan for this 97-year-old person. She had no chance of recovery. Those caring for her felt helpless in the midst of a legal system that is abstract in its reasoning and makes decisions as if medical science does not exist. A well meaning and caring society spends billions of dollars to perpetrate this kind of action upon thousands of dying Americans yearly despite excessive health care costs.

The Patient Self Determination Act passed Nov. 5, 1990, stated that patients have the right to create advanced directives stipulating what they wish done in an end-of-life situation. The act was never intended to mean that those without an advanced directive must undergo care that cannot be of benefit, is disfiguring to their body and draining resources from the rest of society. Quoting from the Philadelphia Inquirer, Nov. 7, 2005, "After three decades of urging Americans to write living wills (they preceded advanced directives), many doctors, lawyers and ethicists concede that these documents have largely failed”. Every case is different and therapy must be individually tailored. Thus it requires knowledge

and judgment to treat in an appropriate fashion. This cannot be done in judge's chambers as an abstract exercise in fine points of the law.

The question to be asked is: does this irrationality in medical care apply only to end-of-life situations in American Medicine? Unfortunately, as has been repeatedly documented on this blog and in my book, the answer is a resounding NO! Dialysis, cardiac catheterization with stents, knee surgery, and excessive use of expensive radiological equipment (i.e. proton accelerators) are only a few examples of medical technologies that, when used appropriately, are terrific, but are being overused and thus abused. No wonder there are not adequate funds available to support primary care and universal heath care coverage.

Why we Need Appropriate Care Committees: A Case Study

Linda Jones was an 87 year old woman who had been in a nursing home for the past four years. She was admitted to the nursing home by her two daughters because of mental deterioration to the point of being unable to care for her self. Since entering the nursing home she had been transferred to the hospital six times. The first, three years ago, was for pneumonia and while in the hospital her daughters agreed to the placement of a feeding tube. However, her daughters were concerned about her over all well being as she did not recognize them and could not communicate in any meaningful way. She appeared to be unaware of her surroundings and did not respond to her name. Her third child, a son, lived thousands of miles away and was not in contact with his mother or sisters. Linda was returned to the nursing home which was now reimbursed at the much higher Medicare rather than the Medicaid rate. During the past three years Linda was readmitted to the hospital five times, twice for pneumonia and twice for urinary tract infection, each time bumping up the nursing home collections from Medicaid to Medicare. Her last admission to the hospital was for sepsis (bacteria in the blood) possibly from her lungs, urinary tract or the small skin breakdown over her sacrum that the nursing home tried diligently to prevent. In the hospital Linda was placed in the intensive care unit (ICU), intubated (breathing tube) and given other medications.

The ICU doctors told her daughters that Linda was terminal. Her daughters agreed with the doctors that she should not under go cardiopulmonary resuscitation (CPR) and should be transferred to hospice, but wanted to wait for their brother who was about to arrive. Linda, like most Americans, had not executed an advance directive nor designated a durable power of attorney. The son arrived and strongly disagreed with the do not resuscitate order and hospice despite meetings with the ethics committee which had agreed with the ICU doctors. The hospital having had unpleasant and expensive legal experiences in such circumstances took no action. Linda remained in the ICU for another three weeks, had a cardiac arrest and died after one hour of attempted CPR. No autopsy was performed.

Linda's ordeal is reproduced in one form or another hundreds of thousands of times in American hospitals yearly. The results are: 1) Linda suffered a disfiguring intrusive death that was an assault on her human dignity. 2) The family as a whole (all three children) was faced with decisions they were not prepared to make and were mired in conflict. 3) Doctors and hospitals have become accustomed to, and in many cases financially dependent on, providing non-beneficial care. 4) The resources consumed were enormous.

What would have happened if my admitting form and appropriate care committee system were in place? Upon Linda's first hospital admission the admitting form would have created a contract between Linda, her family, and the physicians which stated that only beneficial care could be delivered and also would have served as an up-to-date advanced directive. Cardiopulmonary resuscitation would not have been ordered and she would have not had suffered that indignity. Because of her severe and profound dementia the advice of the physician staff likely would have been that after her first hospital admission she should be treated for any complications in the nursing home and if unsuccessful placed in hospice. If conflict arose the appropriate care committee would have been consulted and most likely would have agreed with the physician's plan, as it was reasonable and humane. With committee concurrence the family would have been told that third party payers would not be responsible for other than nursing home and hospice care. Knowing that, the son would have most likely agreed with the plan and family conflict would have been avoided. Our society would have saved significant resources which could then be devoted to universal coverage and other worthwhile goals.

Appropriate Care Committees

No healthcare system, Universal or otherwise, can be efficient, cost effective, and truly serve the best interests of patients without oversight. I'm talking about consistent, uniform, organized oversight by senior physicians, nurses and clergy rather than bureaucrats and accountants who have no knowledge or experience in the practice of medicine. I'm talking about a system of Appropriate Care Committees organized at the local, state and national level created through Congressional action to put the power of the law behind it.

Organized, well-planned action to create uniform Appropriate Care Committees will shift the decision-making to those who know best. It will also be the key to addressing the issues that have gotten our healthcare system in such a mess in the first place. Issues like ICU over-use, especially in end-of-life situations, coronary artery stent over-use, shuttling nursing home patients back and forth from nursing home to hospital even though they cannot benefit from hospital care and need to be in hospice instead, would all fall under the review of Appropriate Care Committees.

I envision a committee in every hospital and nursing home in the country. This committee would be made up of senior physicians, nurses and clergy. It would have the power to cease payment for care that offers no benefit to the patient, and mediate disagreements between admitting physicians and families over options for care. The family could appeal to the committee which would review the case and make a decision based on medical evidence and the individual needs of the patient. This would be particularly beneficial in end-of-life cases where there is wide spread use of non-beneficial procedures and treatment when hospice would be the most appropriate and humane option.

Senior physicians, nurses and clergy would also staff the statewide committee. It would handle appeals from local committees, and oversee the appropriate care committee system within that state. These appointments would be salaried, therefore committee members would have no financial interest in their decisions, These salaries would be paid for by a consortium of all insurers.

A national committee, also composed of senior physicians, nurses and clergy, would oversee the entire system for the nation. National appointments would be similar to those of The Federal Reserve Bank. State and local committee nominations would follow guidelines established by the national committee in concert with individual state medical societies.

Many physicians would object to the system, thinking that it would interfere with their autonomy and could threaten their income. Many others, however, would embrace it for three reasons:

1. It would reintroduce the primacy of the patient-doctor relationship, especially for the primary care physician. It save more than enough resources so that primary care can be adequately compensated.

2. It would provide back up for the physicians who truly try to do their best for their patients, but now have to concern themselves with legal and economic issues.

3. Most physicians believe the present healthcare system needs reform because of excessive costs, lack of care for millions of our citizens, the public's dissatisfaction with the system and our less than stellar health outcomes compared to other developed nations.

There will be oversight. Make no mistake about that. The question is: do we want oversight from non-medical bureaucrats and accountants who are hundreds of miles away making crucial healthcare decisions about what's appropriate and what's not? It's already happening in fits and spurts with Medicare and some insurers, and it's a patient's and physician's worst nightmare.

The Need for Appropriate Care Committees – A Case Study

The burden of decision making in medicine and especially in end of life situations can be painful. We need to feel confident and supported in these difficult circumstances. No one wants to lose a loved one, yet we all know that life is temporary. We need to be sure that the decision to withdraw temporizing measures is correct. Frequently the family, as the patient advocate, assumes they are fighting for the patient and demands the use of multiple gadgets. The doctors comply although knowing they will be of no value. The family thus assumes that perhaps the doctors believe there is a possibility of cure. We need a system to help guide us through an experience that for many, and reasonably so, is very difficult. Following is a case from my own experience that clearly shows why we need appropriate care committees.

The daughter of a patient in the ICU with no chance of recovery was adamant that we continue care. After we exhausted all possibilities as formulated by the AMA Policy to Discontinue Care Against Family Wishes, care was withdrawn and the patient quickly died. After the funeral the daughter came back to the ICU to thank us. She told us that as long as we were willing to care for her mother maybe we thought she did have a chance to survive. But, by withdrawing care she knew we thought survival was impossible and that took the burden of letting her mother go out of her hands.

Section 4 - The Voice of Physicians Should be Heard - Results from a National Survey

Introduction

Since the inception of Medicare/Medicaid we have developed a unique medical culture. We now practice an exceptionally expensive style of medicine. In many cases we reluctantly provide non-beneficial inappropriate care. The new health care law, The Patient Protection and Affordable Care Act is in effect a health insurance law aimed at nearly universal coverage. It is financed in large part by decreases in Medicare funding, targeting mostly physicians and hospitals. Unfortunately this law was not predicated at understanding the reasons why we spend so much per patient and did not make real attempts to address this. The savings could then have been used for funding universal coverage.

This survey is meant to help practicing physicians express their views about our medical societies' role in health care reform, define the fundamentals of why we spend so much/patient and suggest the tools we would need to practice excellent cost-effective medicine.

In response to The Patient Protection and Affordable Care Act, I asked physicians and medical students to complete this survey. It should not be considered professionally done; it is informal and suggestive only.

With enough physician participation I am hoping our voice will be heard by the public and in the halls of Congress.

Highlights from the National Survey, To Date:

1. Three quarters responding did not think medical societies did a good job in representing physician interests.

2. The three reasons why our medical care is so expensive chosen by three quarters or more by the respondents were:

    a. The public practices bad health habits

    b. There is a lack of coordinated care for many patients with chronic disease

    c. There is a fear of adverse legal action

3. The three reforms thought by a significant majority that would help physicians practice a more efficient style of medicine are:

    a. A single national computerized medical record with appropriate privacy safeguards. This was chosen by over eighty percent and is extremely significant. Instead of every office, group and hospital having their own computer system at great cost to the government this opinion is for a central national system that would allow for review from anywhere in the country. This type of system could be paid for by modest user fees and thus would be at no cost to the government.

    b. A payment schedule that would allow primary care doctors to spend at least one half hour in the office with each patient and at least a few visits when their patients are hospitalized. This idea received a two thirds majority.

    c. Sixty percent were in favor of a physician & nurse committee serving as timely consultants to help insure that we deliver only beneficial care and protect physicians from the threat of legal action.

4. So far exactly two thirds of physicians stated that if Medicare decreased payments they would see fewer of those patients. This is especially relevant since over five hundred billion dollars over the next ten years is to be taken from Medicare to pay for about half of the costs of the new health reform law.

5. Over two thirds of respondents were in favor of having each generation pay for its own benefits and not depend on succeeding generations. The same percentage were in favor of this being accomplished by having health saving accounts for out-patient medicine and commercial or government insurance (Medicare/Medicaid) for more costly items and inpatient care.

6. Three quarters of those participating in the survey agreed that drug and device funded research should go through a third party (i.e. The National Institutes of Health) to insure adequate experimental design and reliability of results.

7. Three quarters of those participating in the survey agreed that drug and device funded research should go through a third party (i.e. The National Institutes of Health) to insure adequate experimental design and reliability of results.

The Survey

1. In what State do you practice?

2. How long in practice
   - Still in training (medical school, residency, fellowship)
   - Less than 5 years
   - 5-20 years
   - More than 20 years

3. Type of practice
   - Hospital based
   - Hospital owned practice
   - Small independent practice, < 6 members
   - Medium to large independent practice, > 6 members Your Views

4. Do you think physician interests were well represented by our medical societies during the deliberations in Congress as they created the PPACA?

   o Yes o No

5. In your opinion some of the reasons why our medical care is so expensive include (check all that apply):

   - The public practices bad health habits
   - The public has unrealistic expectations about what medicine can accomplish and the finality of the human life span
   - The advent of medical advertising to the public leads to inappropriate demands and increases costs

- The intense commercial lobbying of Congress causes the Medicare reimbursement system to encourage the overuse of lucrative procedures, technology and drugs
- There is a lack of coordinated care for many patients with chronic disease
- There is the fear of adverse legal action
- There is the delivery of a great deal of non-beneficial costly care
- There is confusion about the limits of patient autonomy
- other reasons

6. In your opinion, some of the tools and conditions that would facilitate physicians dealing with these issues would include (check all that apply):

- A single national computerized medical record with appropriate privacy safeguards
- An amendment to the Patient Self Determination Act which created advance directives to include the phrase, “within the bounds of good medical practice”, to help deal with unrealistic expectations
- A new advanced directive created at each hospital admission with the aid of the medical team to secure agreement and rationality
- A physician and nurse committee, serving as timely consultants, to help insure that we deliver only beneficial care and protect physicians from the threat of legal action
- The creation of a quasi-independent entity similar to the Federal Reserve Bank, thereby Removing Congress from the direct control of Medicare/Medicaid
- A payment schedule that would allow primary care physicians to spend one half hour in the office with each patient and at least a few visits when their patients are hospitalized

- other tools

7. If indeed Medicare further decreases physicians' payments would this cause you to see fewer Medicare patients?

o Yes o No

8. Are you aware that there is cost shifting paid by those with private insurance to help subsidize Medicare and Medicaid?

o Yes o No

9. In this era of changing demographics, would you support the concept that every generation should save for its own benefits and not depend on succeeding generations for support, i.e. the accumulation of funds in special tax free accounts?

o Yes o No

10. Would you support health savings accounts for out-patient medicine and commercial or government insurance (Medicare/Medicaid) for more costly items and inpatient care?

o Yes o No

11. Do you believe that drug & device funded research should go through a third party (i.e. The National Institutes of Health) to insure excellent experimental design and reliability of results?

o Yes o No

Any thoughts or comments

Physician survey about the new health care reform law, The Patient Protection and Affordable Care Act (PPACA), the actual survey can be viewed at http://www.surveymonkey.com/s/makeyouropinioncount