

MEditorial November 2009

Health Care Reformatory

Websters' on-line dictionary defines "reformatory" as: "a penal institution to which especially young or first offenders are committed for training and reformation." I think it may be appropriate to proverbially send many of those legislating current health care reform to such an institution, since (1) by their inexperience in dealing with the everyday delivery of medical care, they act as though they are young and in some cases, "1st time" offenders; ("they know not of what they speak") and (2) the "training" and reformation is best done by practitioners of medicine (and that means especially we doctors) and not even by those pseudo-academics in medical schools/organized medicine and economic hierarchical positions, who are the pretenders to such knowledge.

As a doctor who sees and operates on patients, let me take license in giving these politicians a "reprieve" from reformatory school in listing a few "commandments" which would go a long way toward straightening out the inequities and cost overruns of the current (and indeed, proposed) health delivery system.

#1. Medical malpractice reform. It has to be done. Even more important than the cost of high insurance premiums to doctors is the incredible "defensive medicine" waste by seeing the patient as a potential "legal" adversary and couching the medical encounter in uncertainty. Many illnesses are vague and are more symptoms than actual disease--and we as physicians should be able to tell patients if

we feel there is no significant illness and avoid ordering tests which usually just confirm the obvious. Patients should be able to purchase short-term “accident” insurance policies before, e.g., an operation, which--if there are serious complications (whether due to poor medical performance, the patient’s underlying condition, or tertiary reasons)--would compensate the patient for calculable damages, lost income, “plus” perhaps a certain percentage of patient’s yearly income as a one-time “equalization” payment. Pre-treatment arbitration agreements and doctor-lay health boards should be established to review “malpractice” cases for their merit and create a hurdle over which lawsuits have to pass. We need to have a “loser pays” litigation system to discourage malpractice suits except where there is a clear vision and general agreement of wrongdoing.

#2 More patient responsibility. This entails lowering patient expectations, not guaranteeing great outcomes from medical treatments, and disempowering patients from wanting or needing expensive tests an experienced doctor feels are unnecessary. Those who demand an MRI for a headache deemed by the doctor to be “innocent” should have high co-pay for this; then, let’s say, in retrospect, the MR does show an unanticipated serious problem, the entire cost of the test would be reimbursed by health insurance. Unquestionably, patients should “face” more the economics of the medical system and the cost of their own care, perhaps with higher deductibles and co-pays, especially for minor illnesses. Again if a “chest cold” turns out to be lung cancer, the patient can be reimbursed retroactively without any party “holding blame”. HSA’s (health savings accounts) should be stressed as a private market solution to cost overruns and lack of personal control over health costs. Patients need

to know in some detail their medical history and carry cards (or potentially “thumb” drives or other electronic medical data formats) with them to help us doctors care for them and avoid redundant tests, etc. Some of the privacy laws need to be loosened just enough to allow more unencumbered transfer of data from one facility to another.

#3. Governments’ role: I’d like to see the government only peripherally involved in the management/delivery of healthcare. I agree with some degree of legislation to control excess profits in the insurance industry. Why in the insurance and not other industries? I feel when there is a 3rd party payment system, i.e., health insurance, the “middle man” has too much say over how the healthcare dollar is being spent, what the patient gets for that premium and how much hospitals and doctors get paid. Insurance companies seem minimally covered under anti-trust legislation whereas doctors (solely or in groups) are under the thumb of such laws. Patients, for sure, should not lose their insurance in the middle of treatment for serious illnesses. Perhaps a government option should only be for those with such serious pre-existing illness and relative destitution that forcing insurance of them through the private sector runs up premiums for all others, especially for businesses not able to afford these. By the way, I’d rather see the government pay private insurers for actual policies to cover these high risk individuals than deliver the care by a subsidiary of itself or even formulate a “Medicare-for-all” program.

#4 Providers’ roles. I believe we as doctors and hospitals need to be held to a high standard of ethics, including in the treatments we offer and the billing for these services. There is always low level fraud in the industry, as well as the high profile cases where usually government-run programs, e.g., Medi-Cal (lacking strict oversight) are “ripped-off”

of millions of dollars by unscrupulous providers/business charlatans. This is inexcusable and criminal--but perhaps a "reaction formation" to, and product of, years of declining reimbursements. Given such ethical reforms as well as some of the things discussed above, doctors who put in an honest days' work and use their high skills to the improvement of individuals' health DO need to be paid quite a bit more than we are getting now. I say this unapologetically. Practicing good medicine is time-consuming and can be draining of one's physical and emotional faculties. I do not disagree that outcomes (i.e., good results) as well as hard work and good intent need to be part of the equation for physician compensation. We doctors need to take good histories and examine our patients and frankly, put more thought into what we are hearing and seeing. We need to be less reliant on the automatic referral to other doctors or highly technical diagnostic or therapeutic procedures when simpler solutions are proven to be as effective. We need to determine (and we are doing so) how much it is worth to society to employ a newer test or procedure that is, let us say, only 5% more effective but 3 times as costly as something that already exists. Examples in my specialty include alternate mechanical procedures for prostate enlargement; and use of robotics and laparoscopy for prostate cancer surgery.

To help care for truly indigent patients (excluding those financially capable who elect NOT to partake in the private health care system), we need some creative solutions. Let us as doctors and hospitals commit to deliver uncompensated "pro bono" care (to some extent, we already do this) in exchange for not only tax breaks/ business write-offs but also the satisfaction that such care provides. Consider filling some

of the gaps in care (including for indigents and those in rural areas) by a corps of foreign-trained physicians who, let's say, after 2 years of such (government-salaried) service, can then be free, with minimal bureaucracy, to practice where they choose.

There you have it—principles, to be sure, but more straightforward and intellectually “digestible” than the current nearly 2000 page pending “gobbledygook” legislation being rushed toward law without being able to predict its consequences.

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