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The HIPPOCRATIST

The Official Journal of the Ouachita Medical Society

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OUACHITA MEDICAL SOCIETY

MISSION STATEMENT

The Ouachita Medical Society is a service organization of physicians dedicated to the ideal of a community that is mutually beneficial to physicians and patients.

The Society commits itself to these goals:

1. To pursue and maintain access to quality medical care
2. To promote public education on health issues
3. To provide value to members by the representation and assistance of member physicians in the practice of Medicine

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2014–2016

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OMS PRESIDENT PAGE

By: Adrienne Williams, MD

Greetings fellow physicians, as we encounter more challenges to our medical practice I would like to remind us how individual physicians can make a real difference for all of us practicing here in Ouachita Parish and in Louisiana. In 1975 Dr. John Cooksey of Monroe organized a team to get the then recently passed Indiana malpractice plan enacted by the Louisiana Legislature. Monroe attorney Jessie McDonald was part of this team and Dr. Donald Palmisano was also a crucial part of the effort. Act 817 of the 1975 Louisiana Legislature created the Patient's Compensation Fund. House Bill 1465 became known as the Louisiana Medical Malpractice Act. Dr. Cooksey led the effort to get this passed in the Legislature. He and Dr. Palmisano and others travelled to meet with Indiana state legislators instrumental in the passage of the Indiana Law creating a Patient's Compensation Fund. Dr. Cooksey's and other's efforts were successful and the Act passed and was subsequently signed by Govenor Edwin Edwards.

We all owe a debt of gratitude to Dr. Cooksey and others instrumental in the passage of this law.

The 1975 version of the law included future medical payments in the 500,000 dollar cap. The Louisiana Legislature made an amendment to the Malpractice Act in 1984. This amendment excluded the cost of future medical care from the 500,000 dollar cap on damages and mandated that they be paid by the Patient's Compensation Fund. All other damages must fall under the $500,000 cap.

Individuals do count and can make monumental differences.

We face encroachments on our unique privilege and responsibility during virtually every legislative session as non-physician practitioners lobby to advance their practice autonomy far beyond that which they are actually trained. The optometrists persisted and managed to have themselves declared "optometric physicians" who now have legal cover to do eye surgery. Please stay aware and support physician led efforts to protect patients and improve standards of care. If you haven't done so check out the LSMS website and sign up to receive the daily medical news/legislative synopsis in your e-mail. It is still an honor and a privilege to be a physician. Let's all work together to keep it that way.

Thanks,
Adrienne

CONCIERGE MEDICINE

By: David Barnes, MD

Today physicians in private practice are faced with the ever increasing demands of taking care of sicker patients in an environment of increasing bureaucratic red tape.

Thanks to increasing regulatory burdens of electronic medical records and prior authorizations (permission slips) to approve care required by insurance companies and pharmacy benefit plans, physicians now practice medicine with about the same autonomy as those on house arrest. Not only does this translate into less time spent with the patients and more time dealing with paperwork and phone calls but also increased costs for physicians in solo or small group medical practices. It now requires twice as many employees to care for a similar number of patient as it did 10 years ago. Beginning this year practices that had not reported PQRS (quality measures) data in 2013 will have their Medicare payments cut. Physicians are the only professionals in our society who are not free to package and price the services we offer to the market. Our pay is set by Medicare based on a list of services determined by them and then followed by other health insurance companies. So as all of these new regulations and rules have been added to the practice of medicine, the payment list has remained nearly the same. The only way to increase ones payment for these new mandated government and insurance company requirements is to see more patients or spend countless hours writing protocols and manuals to establish your practice as a certified "something or other". The end result again is less time for patients. This has many primary care physicians heading for the exits. But most primary care physicians love helping their patients. So what choices do they have? They cannot survive much longer in the present medical climate. Those not wanting to retire can sell their practices to large medical groups or wishing to remain independent, look to new models of patient care.

> It now requires **twice as many employees** to care for a similar number of patient **as it did 10 years ago.**

One such model is called the concierges model. MDVIP, a concierge medicine and management firm, was started in 2000 by two physicians in Florida. In 2006 it reported managing 130 physicians but

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Every time you recruit a new member you help strengthen the OMS/LSMS. A vital and growing membership means stronger advocacy power with government and improved educational and social networking opportunities for members.

gained more traction in the physician market in 2009 when Procter & Gamble acquired the company. Now MDVIP has over 700 physicians across the United States.

For the physician, he is able to return to the practice of medicine as it used to be. He is able to finish his charting, lab review, and phone calls by the time he leaves his office.

The basic business model for Concierges Medicine, also known as retainer medicine, is usually a solo primary care practice in which the patient agrees to pay an annual fee or retainer. The average payment for membership in a concierges medical practice is $1,500 to $1,800 per patient per year. Children are usually not charged a retainer or membership fee. In exchange for the retainer, the doctor provides an enhanced focus on wellness and disease management including house calls and hospital advocacy while insuring adequate time for office visits and same day scheduling. The fee includes payment for the many required services not covered by insurance plans. In this model the physician continues to bill Medicare and private insurance for office visits. The Concierge physician also provides increased availability to his patients via phone, email, and text messaging. This means limiting his patient panel from an average of 2500 to 3000 active patients to 600. For the 2000 or so patients who will not pay or cannot afford the annual fee most will be transitioned to a different medical practice. This is probably the aspect of this practice model that gives the physician the most pause. But the trade off is he or she now sees 12 patients a day in the office as opposed to 30 patients a day. He is able to spend time with each patient, review their entire personal and family history with them and monitor their care more closely. He now has time to help them navigate over and around the present roadblocks of our health care system and not be rushed on to the next patient visit. He is able to accommodate all his patients that need same day visits for illness or consultations and not have to triage them over the phone to local walk-in clinics or hospital ER's due to an over booked office schedule.

There are many management companies interested in helping you evaluate your practice to determine if the concierges model is right for you. Their fee is usually a percentage of the retainer fee. They will also assist in legal and personnel changes the physicians practice will need to make along with patient education. The process starts with an analysis of your practice including a survey of your patients to determine the level of interest. Once the company tells the physician it is doable and the physician decides to make this change it is usually a four month process.

Evaluating the cost-benefit of a primary care program directed by MDVIP showed savings of 109 million dollars from Medicare alone, a savings of $2,550 per patient. As for quality measures, this program scored high as well, with fewer non-elective hospital admissions and fewer avoidable admissions than patients in traditional practices.

For the physician, he is able to return to the practice of medicine as it used to be. He is able to finish his charting, lab review, and phone calls by the time he leaves his office. He has time to read his medical journals, keeping up with the latest advancements in medicine, and spend time with his family. It is no longer an "either / or" proposition. But most of all he is again able to experience the joy of practicing medicine.... something he thought was lost and gone forever.

OMS MEMBERSHIP

SERVICE / VALUE

Advocacy
Advocacy for physicians in political, regulatory and economic arenas.

Legal Advice
Providing guidance and assistance to members on a number of Medical-Legal issues affecting physician practices and organized medicine.

Connectivity
Connectivity through special membership activities such as the Oyster Party, the Christmas Party, Doctors Day Reception, Valentine's Social, General Meetings and Executive Committee Meetings.

Business-Over-Breakfast
Allows office managers / business managers from each member's practice to attend a quarterly breakfast where key speakers will cover topics that address areas of concern when managing a medical practice. Everything from medical billing to personnel issues, from fiscal responsibility to safety. We'll cover it all.

Friends of the OMS program
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If your business is interested in applying for the "Friends of the OMS" program please contact the OMS office at:

director@ouachitams.org
318.512.6932

UPCOMING EVENTS

OMS-General Meeting
May 7th 6:30pm
Vieux Carre- Monroe

Business Over Breakfast
TBA-August

OMS-General Meeting
September 10th 6:30pm
Bayou Desiard Country Club

*dates/times subject to change-check www.ouachitams.org for the most up-to-date information

SUBPRIME HEALTH

By: Mark Napoli, MD

The 2008 global financial crisis was triggered by a complex interplay of policies that encouraged home ownership, providing easier access to loans for borrowers, overvaluation of bundled "subprime" mortgages based on the theory that housing prices would continue to escalate, questionable trading practices on behalf of both buyers and sellers, compensation structures that prioritize short-term deal flow over long-term value creation, and a lack of adequate capital holdings from banks and insurance companies to back the financial commitments they were making.

Some would consider the current state of healthcare its own great crisis. A parallel intertwined system of government led policy changes and the desperate speculative reactions of health systems and providers have created some unanticipated economic hardships and barriers to access for consumers and employers. Simple supply and demand is perverted with government interference, payor manipulation, and provider gamesmanship. Furthermore, the manipulation of markets outside of rationale of supply and demand creates a deviation of incentives for the players. The result has created a more fractured care system that costs more for all parties concerned.

Although many years in the making, recent efforts at healthcare reform seems spurred by the contemporary political and economic climate. Analogous to the financial crisis, there are so many intricate moving parts and interplay in the changing mechanics of healthcare and its delivery that it seems impossible to anticipate what the future holds or even what the present contains. Most of the participants in the arena do not have time to take pausing breath that would provide time to survey current circumstances or plan a next move. Players cling hopefully to the advice of speculators and consultants to reassure and direct, just as investors relied on their financial brokers and the cackling din of journalists all posing as financial experts confidently leading their disciples off the cliff of economic ruin.

Some investors began to see the coming implosion of financial markets before the vast majority of us read in the newspapers or watched CNBC tell us all of our 401k's had suddenly overnight become 201k's. A few prescient risk takers actually profited from the collapse by short betting on the outcome. I don't believe that any among us in healthcare will be able to wildly profit from the tumult on the horizon in our industry overnight, rather I think the savvy players are positioning their pieces in a careful but high-risk chess match in order to secure themselves in the healthcare marketplace as either the board master or simply a valuable player piece.

In addition to its own complexity, and in contrast to the financial marketplace, the healthcare sector principles of business are highly irrational. The only isolated incidences of rationality are in areas where the consumer deals directly with the provider such as cosmetic surgery or ophthalmology corneal procedures.

The only isolated incidences of rationality are in areas where the **consumer deals directly with the provider** such as cosmetic surgery or ophthalmology corneal procedures. Interestingly these also appear to correspond to the few areas in **medicine that have become more economical over time.**

Interestingly these also appear to correspond to the few areas in medicine that have become more economical over time. Bizarre as it may seem, even Dr. Oz operates in a more stable and rational financial circumstance in his media pursuits than in his operating room. He reaches more vastly people and earns wildly more income peddling his drivel in five hours on television than he ever did as a surgeon. Despite evidence that the information he reports is highly erroneous and whatever one's opinion of his path, the point is that he capitalizes on his expertise in a much simpler and direct way with advertisers, networks, and endorsees than any in healthcare see money change hands.

Just as in finance and business, inescapable principles exist at the core of supply and demand that persist in healthcare.

Business people refer to this pie when discussing value. Although the relative portion of the slices may change depending on what's most important to the situation, the size of the pie seems to stay the same. If you want more "good", you get less "cheap", less "fast", or both. And so on.

Business thinks about business as good, fast, cheap. The three players in healthcare think about the pie very similarly albeit from different perspectives.

Consumers and Patients

Consumers often find themselves in situations where they either can't afford healthcare or receive care in benefit poor plans. Narrow networks and high deductibles create obstacles that push the entry points of patients downstream in the disease process making the entry point riskier and costlier. Their more advanced pathology compels them to seek care rather than participating in a system that compels them to prevent the pathology in the first place. Patients want effective healthcare. Naturally one wants to become well as quickly and easily if one is ill. They want providers to be available to them promptly that are trustworthy. Ideally building trust with a provider when a patient is well makes him the natural resource when the patient becomes ill. Availability of providers and payers is essential to create that relationship. And patients have to be able to afford the care or the premiums else the first two conditions do not exist. I recently spoke with Dr. Daniel Stein, the new director of the Walmart Rural Health Clinic model present in 17 Walmart stores so far and counting. He told me statistics show 62% of personal bankruptcies in the US stem from overwhelming healthcare costs. Of that group of people, over half have health insurance.

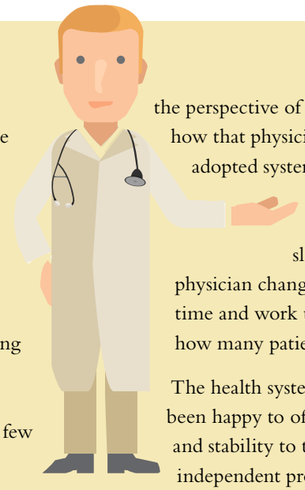
The Affordable Care Act tries to enlarge the Affordable slice of the pie. It requires insurance plans meet minimum requirements of coverage. It provides subsidies for those who would not otherwise perceive to afford insurance, and excludes only the exclusions for coverage. And in doing so, just as the business axiom dictates, the Effective and Available slices get smaller. When asked if Walmart was worried that expanded insurance coverage brought about by Obamacare would undermine the retail rural clinic project, his reply was, "Just because a bunch more people have insurance doesn't mean all of sudden they will be able to see a doctor."

62% of personal bankruptcies in the US stem from overwhelming healthcare costs. Of that group of people, **over half have health insurance.**

Walmart's aim is to capitalize on the lack of available medical care especially in non urban areas of the country by placing mid-level practitioners in their stores in a functional albeit basic medical clinic. For now no physicians will staff the clinics and there are no plans to include them on site. Doctors will only serve as off site supervisors and chart reviewers. The clinics are cash only and do not participate with insurance or even Medicare/Medicaid. As for effective medicine, I asked Dr. Stein about referral structure to either established primary care or specialists for the uninsured or underinsured. He responded that the clinic will rely on the supervising physicians to collaborate or simply direct patients to request charity care in the community for the medical problems that Walmart cannot solve.

I believe that Walmart does not aim to solve our nations healthcare problem. They see a void in the marketplace that is real and pervasive. Dr. Stein says that one out of two patients who visit their clinic do not have a primary care doctor, regardless of wether they have insurance. These direct care clinics will have an impact on affordable and available medical care for both the employees and patrons of rural Walmart stores. Dr. Stein will not go so far as to judge how effective that care delivery actually is. Walmart does however seem confident that those patients who visit primarily or incidentally for care tend to buy various sundry items while there from the small corner of the store still dedicated to retail sales.

Providers and Health System



Providers face many challenges within the realm of healthcare. The stalwart holdout private practice physicians are faced with basically two forces impacting the bottom line despite plenty of patients presenting for care: lack of paying customers and unwilling payers. I met more than a few independent cardiologists at the recent American College of Cardiology annual meeting in San Diego who have had several months within the last year where the revenues only covered their payroll and left them with no income after expenses. A combination of factors including high deductible insurance plans, insurance companies making a decision to outright deny certain tests despite clear medical necessity, and narrowing networks through health system/insurance company contractual agreements have left the independent physician to cope with diminishing return for his efforts all in the face of growing costs for overhead and compliance with regulation.

The result is doctors seeking more stability and shelter from the withering income opportunity of private practice. Just 35 percent of physicians described their practices as independent in a 2014 survey, down from 62 percent in 2008, according to the Physicians Foundation, a nonprofit advocacy group for the profession. Taking a bigger slice of Stability comes at a price. The Value slice changes in nature completely from a patient-provider metric from the perspective of the physician to how that physician fits into his adopted system both financially and politically. The Productivity slice for the employed physician changes to relative time and work units rather than how many patients he helps.

The health systems that have been happy to offer that shelter and stability to the battle weary independent provider will face many upcoming challenges to its survival as well. One of the many facets of the Affordable Care Act is the push to change from fee-for-service to a value-based system. The Value slice of the pie continues to grow in the eyes of the health system CEO. Their entity will eventually no longer be able to assign a fee to every individual service that a patient encounters, but rather the system will profit from value assignments based on population outcomes and patient satisfaction scores. Dr. Ashish Jha at the Harvard School of Pub Health recently commented in an NPR interview in January that at least 1600 hospitals are awarded a distinction on a top 100 list depending on who sponsors the list, a fact that illustrates the vagueness of such metrics.

As payers diminish remuneration or deny classification of inpatient encounters, health systems long reliant on profits from hospital procedures and in-house stays see the Productivity slice of the pie shrink as they pay heavy costs to support personnel and equipment needs for their operating rooms, cath labs, and critical care facilities. The market is quickly adapting and evolving to capitalize on payer and consumer desire to stay out of the hospital. Although imperative to a community, the centralized full service hospital has become a burdensome yolk for the traditional health system in many cases. Accountable Care Organizations (ACO) continue to flourish in the commercial marketplace championed by large organized health systems despite their utter failure to limit costs or demonstrate return on investment for those pioneer Medicare programs and their providers.

The Stability slice for a large hospital appears to be shrinking as well. High employee turnover, hospital and system consolidation, and provider attrition have all made the day to day operation of brick and mortar facilities much more volatile. In addition, a final resolution to the flawed Sustainable Growth Rate formula is in the works in a rare bipartisan Congressional effort. They are of course struggling to find a budgetary solution. One possible rider to the bill is to repeal the Hospital Out-Patient Payment System (HOPPS) that has been in effect since 2000 and allows much greater hospital payments from Medicare to hospitals compared with payments made to independent practices for the same services. This would create a budgetary solution to the new payment formula but cause nothing short of bedlam for facilities that have invested heavily in buying physician practices over the last decade.

Insurers and Employers

And finally the payers such as insurance plans and the employers that cover their workers through premium pay or self insured plans have their own pie with slightly different toppings. Insurers and CFOs constantly analyze healthcare from the perspective of the bottom line rather than how well patients are served. Payers and employers want the biggest piece of their pie to be Low Cost. An argument to support this perspective is that if there is no sustainable method of payment, there can be no provisions for care or coverage. That is a tested and true statement. Look to Venezuela's socialized healthcare system as an example. The Venezuelan economy is in shambles. The March 14-16 weekend Wall Street Journal carried an article exposing hospitals depleted of the most basic supplies having to turn away or even outright discharge critically ill patients.

Payers and employers want the biggest piece of their pie to be **Low Cost.**

President Nicolas Maduro, not surprisingly, diverted blame from his government's economic policies to the government's employed doctors, even going so far as to call them traitors and calling for arrests.

Payers also rely increasingly on high deductible plans to bolster the Low Cost slice of pie. They cost shift the slice of the pie will be crushed. Jon Harris-Shapiro who is a data analyst for Continuance Health Solutions remarks that for his customers over a two year interval, there 26% increase in health related costs for those who have not visited a doctor in the previous year (deemed "the healthy" in company actuaries) compared with 2% with those who have.

gateway medical services and primary care onto their customers and employees with the supposed intent of creating more engaged and responsible healthcare consumers. Payers support Accountable Care Organizations as well. In my opinion their support is founded on their implicit understanding of the model. ACOs are a refined capitated care plan where doctors are paid to do less. And less care costs less money. The law governing the structure restricts primary care providers to one ACO, essentially engineering a narrow network. The intent is to enlarge the Quality slice of the pie without diminishing the Low cost slice.

So if insurers and employers restrict their networks to high quality providers based on data driven models and keep the costs low with Accountable Care and high deductible plans, have they found a Euclidian loophole to the Good/Fast/Cheap circle? Not according to Ryan Schmid, a healthcare analyst and CEO of Vera Whole Health in Seattle. In a recent presentation in Atlanta, Mr. Schmid commented that by payers "unintentionally creating barriers to access and by manipulating a downstream shift in healthcare utilization is creating a ticking time bomb" of late stage, enormously expensive pathology "within the next three to five years". The Efficient

I remain rationally optimistic for the future despite the presently threatening landscape of healthcare seemingly held hostage.

The financial circumstances in 2006-2008 threatened the total collapse of large financial institutions, which was prevented by the rescue bailout of banks by national governments. Even so, stock markets plummeted worldwide. In many areas, the housing market also suffered, resulting in foreclosures, evictions, and profound unemployment. The crisis played a significant role in the failure of key businesses, declines in Global consumer wealth estimated in trillions of U.S. dollars, and a downturn in economic activity leading to the 2008 to 2012 great recession.

Our flawed healthcare system seems poised on the brink of tumultuous change and possible crisis. No doubt there will be a continuation of subsidized essential services. But expect more proliferation then consolidation of some of the more successful models. Expect sacrifice, change, and some failure from all segments of the industry.

I remain rationally optimistic for the future despite the presently threatening landscape of healthcare seemingly held hostage.

Consumers must educate themselves both in health and finance to a degree that makes them able to choose wisely and prepare wisely. (Make a plan or one will be made for you.)

Providers must find a suitable model that allows them to practice real medicine. Doctors must find a way to genuinely and meaningfully care for people in a way that separates them from their competitors. They must create resiliency to market forces that would undermine their commitment to providing best practices. Payers must find a place in the market where consumption and conservatism is balanced with sustainability. And most importantly, all parties must and can find a way to accomplish their goals in a collaborative way.

Financial literacy and health literacy are inextricable. Some organizations are beginning to realize this fact. Shawn Leavitt, the NBC/Comcast Global Vice President of Human Resources and Benefits has phased out wellness programs after realizing they typically result in 10% return on investment and focused on financial literacy counseling for their employees as a more effective means of employee retention thus maintaining access to healthcare from a budgeting standpoint. Pockets of rational private enterprise are already evolving in the new era of healthcare delivery. The Affordable Care Act and its aftermath is creating a Wild West environment that is fertile ground for entrepreneurs. More to come on that.

DIRECT MEDICINE:

THE FUTURE OF MEDICINE?

By: Steven McMahan, MD

As a family doctor, I'm always expecting the unexpected in my typical day. I never know what's going to show up in my office, and that's what I love about my specialty--the variety. What I don't love though, is all the external 3rd party influences & pressures on my practice, and the sinking feeling that I'm simply a overtrained social worker completing forms and entering codes & information into the massive machinery of EMR & insurance companies, to feed the overhead monster I've created as I attempt to grind out a decent living.

And it's getting WORSE! According to the US Department of Health & Human Services, the U.S. can expect a shortage of 20,000 physicians by 2020. Also a recent article in the Annals of Family Medicine projects PCP office visits in the US to increase by 100 million per year by 2025, mainly driven by a growing and aging population. To make matters worse for primary care, a recent AMA survey of third year medical students revealed that only 20% of them were headed into primary care.

So what's the answer?

I would offer Direct Medicine as one piece of the puzzle. Here's how the Direct Primary Care model works: for a flat monthly fee (usually $60-100: that's less than my cell phone bill!) patients have unlimited access to their doctor (in person at the office or via emails/cell phone/texts) for routine checkups, infections, exams as well as chronic disease management & testing such as hypertension, diabetes, COPD, etc. Direct Medicine doctors eliminate fee for service & lower their overhead (not as much billing & collections work chasing claims in this model) while seeing fewer patients. According to Atlas MD, a direct medicine company in Wichita, Kansas, each family doctor in their practice has patient population of about 500-600 and the doctors are making $250,000 salaries.

Patients benefit in the Direct Medicine model by having more access to their doctor who spends more time with them educating & counseling about their disease along with other preventive topics, instead of the rushed pace most of us deal with in the fee for service model. And the patients will save money by obtaining less expensive insurance policies that cover only major medical (hospitalizations,surgeries, specialized testing & care).

"The more you do, the more you make" is the fee for service incentive, and frankly, **it's a failing, flawed system.**

According to Qliance, a direct medicine provider in Seattle, the average savings in their program is 20% versus traditional fee for service providers in their area. And private employers are paying attention. Expedia surveyed their staff last year & noted a 95% satisfaction rate with their Qliance doctor and the financial arrangement in this program. Dr. Garrison Bliss, founder of Qliance, reports improved physician morale in this model because the typical fee for service hassles are eliminated. As Dr. Bliss notes in a recent Time magazine article, "There are no insurance codes for 'cure.'" Dr. Bliss also notes his group is having the same successes in his state's Medicaid program.

Another positive by product of direct medicine is lowering utilization. By using more quality primary direct care, less specialized care & services are needed. Patients have their problems diagnosed & managed sooner, before any true crises arise, which would lead to expensive hospital stays or specialty care. The fee for service model doesn't support this approach, as it mainly pays providers for treating disease, not preventing it. "The more you do, the more you make" is the fee for service incentive, and frankly, it's a failing, flawed system. As long as this system(led by Medicare) monetarily values surgeries, scans & procedures more than checkups & disease prevention, expect more of the same.

Maybe Direct Medicine is a good idea & will endure. Maybe not. But this model is intriguing to this family doctor running on the fee for service treadmill!

Author Note: Atlas MD has an excellent website with a wealth of information regarding the Direct Medicine model, for those interested in learning more on this topic.

THE OUACHITA MEDICAL SOCIETY

UNIVERSITY HEALTH-CONWAY

SCHOLARSHIP

The Ouachita Medical Society will be awarding two PGY2 University Health-Conway Residents with monetary scholarships. The monetary prizes may be used completely at the discretion of the winners. The winners will be announced and awarded at the September OMS General Meeting.

In order to qualify, residents must:

- be entering the PGY 2 phase of their residency at University Health-Conway (Monroe, LA)
- submit in-service exam scores
- complete the scholarship application
- complete the essay questionnaire
- submit a staff recommendation letter
- appear for a final interview before the OMS Executive Committee

1st Prize
$1000

2nd Prize
$500

WHAT WERE THE ROOTS OF THIS HOSTAGE CRISIS?

By: Robert Hendrick, MD

The topic of this month's issue is "Healthcare Held Hostage". What were the roots of this hostage crisis? I would say that we have to look back to the creation of the Medicare program in 1965. Prior to that time, there was limited third party involvement in the doctor/patient relationship. There was a great deal of consternation and concern that this relationship was going to be greatly affected if the Federal government got involved in the economics of healthcare. This being one of the most conservative areas of the country, there was great reluctance by some institutions to get involved. As a matter of fact, a Highland Hospital in Shreveport and one (St. Francis) in Monroe were among the last hospitals in the country to enroll in the Medicare program.

What was the thinking behind this? Such institutions were taking an ideological stand against the government's intrusion into healthcare. It is my understanding that there was local support for this move. Members of the community applauded this stand. That is, until it began to affect their pocket books. Virtually all hospitals had joined the program within a year because most seniors chose facilities in which they could participate in this new federal program. The recalcitrant facilities had no choice but to join in.

Besides ideology, what were their reasons for not wanting to join? Among the biggest was the overutilization of services. Before Medicare, there were relatively minor problems that seniors chose to live with or to tolerate. Since the government was willing to pay the bill, why not get it taken care of? As can be seen in retrospect, the government greatly underestimated this phenomenon. Medicare has been struggling since its inception with how to control the unforeseen increase in healthcare spending. Physicians and other healthcare providers are not totally blameless in this phenomenon either. Those less scrupulous have taken advantage of a system that is extremely hard to oversee because of its sheer size. This doesn't even touch on more morally complex issues like end of life care. It is easy to be oblivious to the inevitable when the cost of care does not affect a particular individual.

What have these and other problems lead to but over-regulation of the doctor/patient relationship. As the government has struggled more and more to oversee the reimbursement of physicians, more burdens have been placed on physician's time. There once was time to have a meaningful conversation with a patient during an office visit. Now as we have been inundated with electronic medical records and more and more need for documentation, there is less time for the patient. This also leads to more time and cost spent on administrative tasks outside patient care. No wonder physicians suffer burnout, seek employment versus private practice, and seek early retirement. Hospitals are also burdened by these regulations. They also have to devote more resources to document that they are providing quality care and are given less and less reimbursement to achieve that. Is there any business where reducing capital will result in an improvement in quality? That would be a very difficult goal to achieve.

> So were our local institutions **right** in trying to take a stand **by not participating** in the new **Medicare Program?**

So were our local institutions right in trying to take a stand by not participating in the new Medicare Program? Certainly they saw what the road to good intentions could lead to but a stand by a few was not going to change the tidal wave of social reform at the time. And there was a need for a safety net for the financial burden catastrophic illness could impose on senior citizens. What I think as the Patient Protection and Affordable Care Act has shown that something as complex as the major overhaul of the healthcare system is not handled well in the political maelstrom. It is something that all involved parties should address together. But the question is, how do we get there?

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Adversity Breeds Innovation

By: Timothy Mickel, MD

I pulled into the drive-thru and gazed at the menu board for what seemed like several minutes as my mind drifted off on a scent cloud of cayenne and hot grease in the blue-gray of early evening.

"Malp you?" (May I help you?) Came a distant voice over the box.

"I'll have twenty units of Botox and a tall syringe of Juvederm - with lidocaine if you have it."

"Will that be all?"

"Yes ma'am"

"OK, drive around. The next available injector will be right with you."

Before you say, "huh?" consider this:

Thirty years ago, who would have thought you could have your gallbladder removed through a scope and go home the next day, have your coronaries opened without having your chest cracked, have a robot venture deep into your pelvis and shuck out your prostate or go to Wal-Mart and get a dozen eggs, a bathroom rug, a box of shotgun shells and a gram of Rocephin. So it's not too far-fetched to think that drive-thru plastic surgery services are just around the corner.

Plastic surgeons have always been at the forefront of surgical innovation. Unencumbered by grave and weighty issues like dead bowel, ruptured aneurysms and poorly differentiated malignant astrocytomas, our minds have been free to roam the creative hinterlands where art and science overlap. The fruits of this intellectual freedom have been life changing, and at times, truly spectacular. Sure, plastic surgeons were pioneers in transplant surgery, but who would've thought that putting silicone gel into an implantable silicone bag would change humankind forever? And how about hooking a hose to a vacuum cleaner and sucking out fat? Those weren't just frat boy pipedreams; those were real advances.

You have to admit, this issue of The Hippocratist is full of some pretty depressing stuff on the sad state of medical practice in this age of EMR and "no touch" patient care - depressing even for a guy like me accustomed to upbeat, light-hearted issues like love-handles, cup-size and nipple sensation. But let's not collectively languish in a digital dungeon, or slowly perish in a white paper penitentiary. As a plastic surgeon, I see a huge ray of sunshine piercing this gloom.

It truly is the wild, wild west out there, and like sunshine on a cloudy day one of the many unintended consequences of Obamacare is that it has thrown the door wide open to creative entrepreneurs who are willing to be innovative, take risks and work outside the system. Modern humans love to multitask. We are busy; and busy people are important people. Modern healthcare is digital; and will be increasingly dependent on digital devices in the future. Not just big machines that cost millions, but small hand-held, or even implantable, devices that only cost a few thousand.

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At this intersection of social science and hard science lies an entrepreneurial space where creativity and innovation also intersect. Strategic thinkers will realize that the real opportunity lies not just in devices that diagnose and treat, but in devices that make our lives more convenient, interesting and fun.

As you might expect, Apple has already thrown its hat into the "lifestyle" medical device arena (see insert),

Apple does it again!

Apple announced today that it has develped a breast implant that can store and play music. The iTit will cost from $499 to $699, depending on cup and speaker size. This is considered a major social breakthrough because women are always complaining about men staring at their breasts and not listening to them.

and apparently, there are several similar devices in the pipeline. For example, iJohnson will come equipped with a "smart" receiver that can interpret subtle verbal and postural messages, and based on this input link with iTit via a Bluetooth connection to select the appropriate mood music - classical, rap, rock, Sinatra, etc - for the situation. High-end models even dim the lights.

"Sir! I said you could drive around"

"Oh! Sorry! I was daydreaming.
Look, just hold the Botox and fillers for today, and give me a five-piece box...spicy. And could you hurry, my wife is playing my tune."

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