



## Not Your Father's Board

### EDITOR'S MESSAGE



By Ed Rudin, MD

In the 50 years I have belonged to my local, state and national medical societies, I have dismissed my local Board of Directors as irrelevant at best and oppositional at worst.

When I was a senior medical student, the renowned Morris Fishbein, MD, AMA President and JAMA editor, addressed my class. He fulminated against social security as "New Deal socialism" and vilified Harry Truman, who, but for the AMA, would establish "socialized medicine" and deprive physicians of their birthright.

A couple of years later, when I joined my local, state and national medical societies, they were fighting Kaiser-Permanente as "socialized medicine." My local society suspected me of disloyalty because I was directing a state-funded mental health clinic - besides being in private practice.

In the 50 years I have belonged to my local, state and national medical societies, I have dismissed my local Board of Directors as irrelevant at best and oppositional at worst. I liked and respected the individual doctors who served on the board and I worked closely with officers and committee chairs of the CMA. But I avoided what I saw as a self-perpetuating band of guild-protecting senior physicians determinedly blind to the unmet medical needs of the unserved, poorly served or underserved.

Since being on the Editorial Committee, I have learned more about our local board and have come to respect its thoughtful resolution of serious problems - pain control, air and water pollution, emergency services, and the quality of medical services to medically indigent people. This board no longer frets about admitting physicians of color or physicians trained offshore - or how to get exemptions from parking tickets.

As Editor, I have directly observed and reported on the issues before the board and the actions it has taken. The meetings have been a revelation.

This is not Morris Fishbein's board. This group is keenly, even painfully, aware of patient as well as physician needs, of the conflicts and seeming incompatibilities of values and interests.

Today's physicians, like medicine itself, are far more diverse than in Morris Fishbein's time, and our local board reflects that, albeit imperfectly. Instead of relying on stereotypes and shibboleths, it studies the diverse views, listens to diverse opinions and findings, looks for points of convergence, and probes to find the least intrusive way to provide a structure for resolution.

The year's most notable examples were how it handled a perceived shortage of physicians and allied health care professionals and of concerns about newspaper advertising to promote self-referral for case-finding imaging.

In the first example, the board studied the literature, encouraged a local study of physician-patient ratios and trends, examined reports of nursing shortages, and asked how doctors could use all health care personnel more efficiently and effectively - while protecting and promoting the quality of care. The board continues to seek microcosmic solutions while the state and nation seek macrocosmic solutions.

With the help of Society committees and others, the board has discussed the crisis of access to emergency departments and specialty care, the multiple causes and the impact on patients, physicians and other medical staff. It weighed the need to cut costs in the face of personnel shortages, poor reimbursement and the effects on quality and on timely access - and what physicians can do about this.

The concerns about newspaper advertising of self-referral for diagnostic radiology elicited near-Solomonic wisdom. The board invited representatives of the largest local radiology services to meet with it and answer questions about procedures, responsibilities, clinical rationales and expected impact on patients and practice patterns. Dr. Ostrich wrote about this in our September issue.

The radiologists involved, all thoughtful and ethical members of the Society, forthrightly described what they were doing and why, and earnestly considered whether and how they could best protect patient choice and access without fragmenting patient care, increasing patient risk or unduly intruding on previous physician-patient relationships.

The discussion was collegial, not competitive; clinical, not political; enlightened, not judgmental. It respected the newly-revised AMA Code of Ethics that reasserts and elevates the principle that the physician has a primary responsibility to the patient, regardless of self-interest or third-party payer or provider interest.

Our officers and our board deserve our admiration and respect.

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