



## Voices of Medicine

---



By Del Meyer, MD

**The wrong way to fund stem cell research and ERs, why one gynecologist went back to fee-for-service, the severe impact on adults of their childhood experiences.**

### CMA and Stem Cell Research

"The California Medical Association has endorsed the California Stem Cell Research and Cures Initiative that will earmark \$3 billion for embryonic stem cell research to develop cures for Alzheimer's and other debilitating diseases." That one sentence in *Southern California Physician* continues the confusion of equating embryonic stems cells that have never cured any diseases with adult stem cells that have shown promise in curing a large variety of diseases.

President Bush used his first televised presidential address three years ago to put the emotional issue of embryonic stem cell research behind him. The federal government would, for the first time, provide funds for the research, but wouldn't pay for work that required new embryos to be destroyed. Scientists and patient advocates who wanted the funding spigot fully opened grumbled but accepted the decision - as did abortion foes who wanted the work banned.

With that compromise, President Bush alienated both camps: Orthodox Jews, Evangelical Christians, Catholics and Muslims for extending the research from stem cells to embryonic stem cells; and scientists, including Nobel laureates, and large hopeful patient groups. for preventing unlimited embryonic stem cell research. Yet, Bush is the first President to authorize any tax funding of embryonic stem cell research.

Opponents of stem cell research say it's unethical to destroy embryos and that using stem cells found in the bone marrow of adults could accomplish the same goals. President Bush has also praised the potential of adult stem cells. Stem cell scientists say adult cells aren't as abundant and malleable as embryonic cells. Other scientists say embryonic stem cells have yet to cure any disease, have limited potential to do so and carry a high risk of teratomas.

It is important that the CMA, composed of physicians from the same spectrum of society noted above, not take sides on such divisive issues. It destroys the collegiality left in organized medicine. Who then will be the Voice of Medicine?

### Resuscitating ERs with a 911 Tax Increase

Dina Burwell reports in *Southern California Physician* that the Coalition to Preserve Emergency Care (CPEC) has a solution to the crises in the emergency rooms - a 911 tax initiative. The California Healthcare Association announced in April that it was dropping out of the 911 initiative because of a downward spiral in voter support. CHA thinks we should come up with something more publicly acceptable to fund the safety net. CMA should have dropped out also.

There are already seven taxes and four surcharges and fees on my telephone bill. There are hundreds of worthwhile causes and this is certainly one of them. But how many taxes

are reasonable? When will it all end?

Because we have limits on our primary taxes, a more worthwhile CMA policy might include a tax-limiting initiative. Instead of a myriad of taxes, surcharges and fees, it seems we need a federal constitutional amendment limiting each branch of government to two taxes. The American Taxpayers' Union has several proposals. Another could be to limit the feds to a 15 percent income tax and a 10 percent excise tax on interstate commerce and imports, limit the states to a 5 percent income tax and a 5 percent sales tax, and limit the counties to a 1 percent property tax and a 1 percent sales tax. The addition of these taxes is still more than the 25 percent cost for government that public polls indicate Americans feel they should not have to exceed.

These limitations would bring order out of chaos and credibility to government. They would also increase the enthusiasm for joining the CMA and county medical societies. They could even restore our membership from the current 40 percent of all physicians to its former 80 percent, when we advocated private practice solutions instead of government-based solutions.

### **Making Practice Choices**

When I was serving my two military years at the Mather AFB Hospital, the base commander felt active duty personnel were waiting too long to be seen. So the hospital commander shortened the time for military dependents' medical appointments. Women who required pelvic examinations had previously been given 30-minute appointments; these were reduced to 15 minutes. He said that having the women draped for the pelvic exam prior to seeing the doctor would conserve time. I asked if he thought it was somewhat vulgar to introduce himself to a new female patient from between her thighs as he's preparing to insert the vaginal speculum? He did not.

Ricki Pollycove, MD, a gynecologist writing in *San Francisco Medicine*, reviews her decision to leave insurance-dependent private practice and make the leap to fee-for-service medical practice in 1997. She had observed the development of managed health care deep in the medical soil of the Bay Area in the mid-1980s.

Physicians signed onerous managed care contracts that guaranteed them access to large numbers of patients, hoping to compensate for the loss in reimbursement for services. Participating providers (doctors) struggled to undercut competitors, keeping their market share of subscribers (patients).

The sacred physician/patient relationship for gynecologists became encumbered by "primary care provider (PCP) gatekeeper" rules. Frustration for consumers (patients) and providers (doctors) rose to levels of dissatisfaction never before witnessed.

Dr. Pollycove had been deeply satisfied with her role as an academically grounded and psycho-socially sensitive gynecologist providing comprehensive integrative care for all aspects of her patients' physical and mental well-being for 16 years. By 1977 she was at an impasse. "My attentive personalized style of practice, offered in the manner in which I would want my mother, friends and self to receive care, was no longer financially sustainable due to declining reimbursement rates." She no longer could make a living with a minimum 20-minute patient appointment.

Rather than being seen as an elitist or snidely referred to as a "boutique doctor," she honored her nature and practice-pace comfort zone and resigned from the encumbrances of the PPO-HMO insurance world. She now sees 15 percent of her patients at little or no charge.

To read the entire article as she explains how "life is good" and "patients are wonderful" and review other articles in the annual Women's Issue, go to [www.sfms.org/sfm/index.htm](http://www.sfms.org/sfm/index.htm).

## Voices for the Voiceless

The recent Mercy San Juan Medical Grand Rounds gave a whole new perspective on adult illnesses. Vincent J. Felitti, MD, reported his studies of the Kaiser Permanente Medical Care Program in San Diego on the Relationship of Adverse Childhood Experiences to Adult Illnesses. Most physicians have little comprehension of how childhood experiences translate into adult illnesses.

The Adverse Childhood Experiences Study (at [www.acestudy.org](http://www.acestudy.org)) is an outgrowth of observations made in the mid-1980s of an obesity program that had a high dropout rate. The first of many unexpected discoveries was that the majority of dropouts actually were successfully losing weight. Accidentally, and to our surprise, we learned from detailed life interviews of 186 such individuals that childhood sexual abuse was remarkably common and, if present, always preceded the onset of their obesity. Some had brought up their history of abuse only to have the information rejected by a physician as being in the distant past and hence not relevant to current problems.

The counterintuitive aspect was that, for many people, obesity was not their problem; it was their protective solution to problems that previously had never been acknowledged. An early insight was the remark of a woman who was raped at age 23 and gained 105 pounds in the subsequent year: "Overweight is overlooked and that's the way I need to be."

The contrast was striking between this statement and her desire to lose weight. Many were driving with one foot on the brakes and one on the gas, wanting to lose weight but fearful of the change in social and sexual expectations that would be brought about by major weight loss.

The 26,000 consecutive adults coming through the Department were asked if they would be interested in helping understand how childhood events might affect adult health status. Seventy-one percent agreed. These volunteers were asked how many ACE events they were exposed to.

Adverse Childhood Experiences (ACEs) are defined as growing up (prior to age 18) in a household with:

- recurrent physical abuse;
- recurrent emotional abuse;
- sexual abuse;
- an alcohol or drug abuser;
- an incarcerated household member;
- someone who is chronically depressed, suicidal, institutionalized or mentally ill;
- mother being treated violently;
- one or no biological parents;
- emotional or physical neglect.

An individual exposed to none of these categories had an ACE score of 0; an individual exposed to any four had an score of 4, etc. The two most important findings are that these adverse childhood experiences:

- are vastly more common than recognized or acknowledged; and
- have a powerful relation to adult health a half-century later.

One in four were exposed to two categories of adverse experiences; one in 16 were exposed to four categories. Given an exposure to one category, there is an 80 percent likelihood of exposure to another category.

A person with an ACE score of 4 is 260 percent more likely to have COPD than a person with an ACE score of 0. A person with an ACE score of 4 has a 240 percent increase in developing hepatitis; a person with an ACE score of 4 has a 250 percent increase in contracting sexually transmitted diseases; a male child with an ACE score of 6 has a 4,600

percent increase in the likelihood of later becoming an IV drug user.

The same correlation occurred with emotional disorders. An individual with an ACE score of 4 or more was 460 percent more likely to be suffering from depression, 1,220 percent more likely to attempt suicide. The totals went to 3,000-5,100 percent with higher ACE Scores.

The Kaiser study found that 22 percent of their members were sexually abused as children. How does that affect a person later in life? How does it show up in the doctor's office? What does it mean that sexual abuse is never spoke of?

Dr. Felitti asked what is this hypertensive, diabetic old woman's diagnosis? He conceptualized the problem this way:

*Childhood sexual abuse*  
*Chronic depression*  
*Morbid obesity*  
*Diabetes Mellitus*  
*Hypertension*  
*Hyperlipidemia*  
*Coronary artery disease*  
*Macular degeneration*  
*Psoriasis*

Dr. Felitti concluded: This is not a comfortable diagnostic formulation because it points out that our attention is typically focused on tertiary consequences, far downstream. It reveals that the primary issues are well protected by social convention and taboo. We physicians have limited ourselves to the small part of the problem, where we are comfortable as mere prescribers of medication. Which diagnostic choice shall we make? Who shall make it?

And, if not now, when? For more details, go to [www.cestudy.org/docs/GoldintoLead.pdf](http://www.cestudy.org/docs/GoldintoLead.pdf)

[delmeyer@healthcarecom.net](mailto:delmeyer@healthcarecom.net)

Sierra Sacramento Valley Medical Society  
5380 Elvas Avenue #100 • Sacramento, CA 95819  
916.452.2671 PH • 916.452.2690 FX • Email: [info@ssvms.org](mailto:info@ssvms.org)

Copyright © 2000-2008 Sierra Sacramento Valley Medical Society - All Right's Reserved