



## Do No Harm

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By David J. Gibson, MD

THE FIRST LESSON EACH OF US LEARNED when we entered medical school was to "do no harm." We understood that it was a privilege to learn an ancient art that had, only recently, attained a scientific basis for diagnostic and therapeutic decision-making. We also were taught that this knowledge had great power that could be used for good - or for evil. Our oath upon entering the profession was to use this knowledge for the good of our patients and our society.

Recently published data from the Center for the Evaluative Clinical Sciences at Dartmouth Medical School<sup>1</sup> has demonstrated that our performance here in California is not squaring with our ideals. This authoritative research demonstrates that California's allocation of limited resources to high-tech diagnostic and therapeutic modalities is actually harming both our patients and our society.

The Dartmouth analysis of Medicare data demonstrates significant variations in the use of hospital resources for the care of chronically ill elderly patients. Studies are now demonstrating that lower utilization of acute care hospitals and physician visits actually lead to better results for patients.

Approximately 27 percent of Medicare's annual \$327 billion budget goes to care for patients in their final year of life. The Dartmouth Group specifically evaluated the use of the hospital during the last six months of life.

- While California is in the second highest cohort for bed day utilization, it is in the highest cohort for the use of the intensive care bed.
- California ranks high in the use of the intensive care unit during the last six months of life.
- California is ranked in the highest cohort for physician visits per decedent during the last six months of life. California ranks in the top cohort for deaths associated with admission to the intensive care unit.
- Though ranked in the highest cohort for admission of the terminally ill to the ICU, California ranks in the second tier of cohorts for the use of hospice care as an alternative.

The amount of money the Medicare program spends per patient with severe chronic illness varies substantially across the country. At \$38,573, California ranked third nationally among all states in spending per patient. California spent 32 percent above the national average. The overuse of the most expensive resource in health care here in California can be directly attributed to the fact that we have too many procedure-oriented specialists making clinical management decisions. In states with higher ratios of primary care physicians in the labor pool, specialists serve primarily in a referral capacity. Here in California we have the highest concentration of specialists in the country.

The primary responsibility for the oversupply of both specialty physicians and high-tech resources in California can be directly attributed to three sources: the medical schools, the hospitals and the California Medical Association (CMA).

We have eight medical schools in California, each generating far more specialist physicians than generalists each year. This problem is compounded by teaching hospitals that offer post-graduate training of specialty physicians. From a public policy perspective, California's medical schools have failed to provide the state with a viable health care model for the future.

As a state, we invest far too much of our limited health care resources in hospital-based care. These institutions consume a disproportionate amount of health care dollars and strangle investments in low-tech community-based alternatives for care, as is the norm in most states. By providing expensive technology, hospitals enable specialists to opt for expensive care options as the default.

The CMA has played an important role in producing this health care public policy disaster in California as well. The CMA has relentlessly supported the growth of the hospital-based delivery system by endorsing every initiative that increases funding for our fundamentally flawed system. Examples are numerous, ranging from Proposition 86 on this November's ballot to the California Health Insurance Act of 2003 (SB 2), which became Proposition 72 the next year and was rejected by voters. In each instance, the CMA has sought to infuse more funding rather than lead efforts to reform the fundamentally flawed delivery system. The CMA has constantly obscured, obfuscated and obstructed any effort to challenge the power of the hospital in California's flawed delivery design.

This misallocation of health care resources is a direct result of the clinical decision-making by physicians in California. These decisions have and are generating significant deleterious consequences.

The cost of health care is inflated in California above all western states and most of the country. As a result, all of California's government entitlement obligations are now actuarially destabilized at the state, county and individual political subdivision level. We all pay higher taxes to cover inflated health care costs and our children face the likelihood of confiscatory tax rates in the future. Simply stated, these health care entitlement costs are not sustainable.

Unless California can redirect the pattern of high cost health care resource utilization, it will never be able to address and solve its structural budget deficit, which now is projected to be above \$4.5 billion for fiscal 2007-08.

Every citizen in California has a stake in solving this health care cost problem but physicians, as the primary contributors to the problem bear a unique responsibility. Remember whence we started - do no harm.

Some may find a frank self-critical discussion such as this to be infelicitous - obviously I dissent from that opinion. It is important that physicians openly address these matters.

Self-criticism is the weak spot of any voluntary organization. Presenting a construct in which physicians are heroic and above criticism sells well, but it represents a simplistic, monochromatic way to look at complex issues. Organized medicine's position on balance billing is but the latest example of comforting the comfortable.

In the past, physicians have played a role of leadership in health care - not mid-level employee managers as is the case today. To reclaim our heritage, physicians should, with confidence, confront issues that are being debated in public policy forums here in California.

Unless we reverse the existing trend, we will continue to be categorized as yet another self-serving special interest group. Special interests are uniformly marginalized and managed. They are not viewed as a public resource that should play a pivotal role in the redesign of an essential service.

Physicians may continue to willfully exclude themselves from the substance of the debate now underway. That will be a mistake. The price of admission is to clearly understand and openly acknowledge our contribution to the flaws in the current system.

Reform is coming to our health care system here in California. The only relevant question is - will we have a constructive role to play in the redesign of that system?

To do no harm does not support our sitting by while organizations who speak for us in the forum or corporations that now profit from our decisions pose as self-serving interests that defend a flawed status quo. A consensus has been achieved. The status quo is not sustainable.

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- The Dartmouth Atlas of Health Care 2006; Center for the Evaluative Clinical Sciences (CECS) at Dartmouth Medical School.

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