



Voices of Medicine



By Del Meyer, MD

The impact of prayer on recovery, and deciding whether to stay with Medicare.

Proof and Prayer

Emily Dalton, MD, discusses "Science and Intercessory Prayer" in the November 2006 issues of *The Bulletin*, published monthly by the Humboldt-Del Norte County Medical Society.

'Intercessory Prayer Ineffective!' touted the headlines in the medical periodicals when a major study on intercessory prayer and recovery from cardiac surgery was published in the *American Heart Journal*. The study looked at about 1800 post-op CABG patients and assigned each to one of three groups: 1) receiving prayer after being informed that they *may or may not* be prayed for, 2) *not* receiving prayer after being informed that they may or may not be prayed for, and 3) receiving prayer after being informed they *would* be prayed for. The complication and mortality rates were monitored. The authors concluded that the prayer had no effect on complication-free recovery from CABG, but that the *certainty* of receiving intercessory prayer was associated with a higher incidence of complications. Well, that doesn't sound good. It's hard to imagine how knowing you are being prayed for could increase your likelihood of post-surgical complications. In fact, the authors could think of no possible explanation for the results, and postulated chance as the most likely reason.

I think this study has some major limitations. The underlying assumption, which is not stated, but clearly implied, is that prayer should work in a simple 'ask and you shall receive' manner. This is a very immature approach to prayer, akin to a young child who asks God to grant him a new bicycle. Most people who pray do not expect instant, specific wish gratification, yet this does not deter them from praying nor does it detract from the value and importance of prayer.

The benefits of prayer may be hard to measure - they may occur at varying times and may affect the recipient, the person doing the prayer (stress reduction, lowered blood pressure), or the world at large. Prayers come in many various forms, including supplication, praise and worship, undefined, requests for self-transformation and so forth. One can pray for acceptance of the will of God, such as when Jesus prayed, "not my will but Thine be done" prior to his crucifixion. Some people pray without understandable words, and leave it a mystery as to what their prayers may be about - even to themselves. I don't think one can conclude much about the overall value of prayer from one study looking at one outcome from one type of prayer.

"Here is the real paradox: Belief in God is supposed to require a leap of faith. If you could prove the effectiveness of prayer, then belief in God would not require faith and would thus invalidate the initial premise. So, in a sense, the results of this study confirm what we

know about God, that belief in God requires faith, not proof. To reiterate, faith is about belief I proof. Science is about belief *based* on proof. These two are like yin/yang opposites, and this is why using science to study religion doesn't work well..."

The entire article is at www.humboldt1.com/~medsoc/images/bulletins/NOVEMBER%202006%20BULLETIN%20for%20web.pdf.

Opt out of Medicare?

David Goldschmid, MD, President of the San Mateo County Medical Society, focuses on "Medicare's Web" in the *SMCMA Bulletin*.

The current concern to most physicians about Medicare is that Medicare reimbursement rates are not keeping up with practice costs as costs continue to rise. This leads one to consider changing one's Medicare status from a participating physician to another category. Are there any economic advantages to becoming a nonparticipating physician? Does it make sense to opt out of Medicare?

Recently we have heard several politicians informing us that Medicare's current reimbursement rates are acceptable as proven by classic economic indicators. They quote statistics that show a gradual increase over the past few years of the number of physicians who participate in the Medicare system. In this column I will outline the alternatives for physicians, and as you will see, the usual economic principles governing trade do not apply to Medicare. The options for physicians who treat the elderly are very limited.

Medicare recognizes three categories for physicians:

1. Participating

This category is the most familiar. These physicians accept Medicare's allowed charges as payment in full for all of their Medicare patients. Medicare pays 80 percent of these charges directly to the physician and the patient (or supplemental insurance) must pay 20 percent. If the patient has supplemental insurance, Medicare automatically forwards medigap claims to the appropriate carrier for payment. Medicare pays participating physicians 5 percent more than nonparticipating physicians. Participating physicians are included in Medicare directories. Medicare carriers process claims of participating physicians more quickly and provide toll-free claims processing lines.

2. Nonparticipating

These physicians may decide on a case by case basis whether to accept assignment or to bill their patients more than the Medicare fee schedule. There are federal laws limiting what these physicians may charge. The effect of these laws combined with the 5 percent reduction provided in Medicare regulations have a net effect of allowing these physicians to charge 9.25 percent more than participating physicians. The payments go to the patient and must be collected from the patient.

3. Opt-Out

These physicians do not participate in the Medicare program at all. They may treat Medicare patients using private contracts with the patients and may charge without the limits imposed by federal law. These physicians may not submit any claims to Medicare for a two-year period. Their patients may not be reimbursed by Medicare, or a supplemental insurance carrier, for any item or service furnished by the physician that would have otherwise been covered by Medicare had the physician been participating. It seems unlikely that any but the most wealthy Medicare-aged patients would accept this.

Several other principles are worthy of mention. The first is that participating physicians may only change their status to nonparticipating during a short 'open enrollment' period. Second, the government has shown its willingness to aggressively prosecute nonparticipating physicians for repeatedly violating the assignment agreement. Third, contracts between patients and opted-out physicians are complex and may require legal review. Finally, rules for treatment of emergencies are completely different, causing confusion.

So it seems that opting out means that you have basically decided not to treat any Medicare patients. Becoming a nonparticipating physician means you can increase your charges by a meager 9.25 percent in exchange for significant possible collection problems. The choices suggest that the only recourse we have to the dilemma of falling reimbursement is to fight the political fight to improve reimbursement or to limit access to optimize the expenses-to-cost ratio of running a practice. Once again, we need to stick together.

The complete article is at
www.smcma.org/Bulletin/BulletinIssues/Oct06issue/President.html.

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