



Useful Idiots Revisited



By Lee T. Snook, Jr., MD

"Peer review" in chronic pain cases is neither "peer" nor "review."

RECENTLY YOU WERE ENLIGHTENED by one of our legal colleagues who had the courage to call a spade a spade. He outlined the complicity of physicians acting in their capacity of contracted or employed emissaries of the insurance industry, in this case workers' compensation, to perform "peer review" (see "Useful Idiots," SSV Medicine, September/October 2006). The purpose of this review is to further the report.

I must inform you, my colleagues, that this sham called peer review is neither "peer" nor "review." I have many examples and will share some with you.

First on the subject of "peer." I am a board certified anesthesiologist, internist and pain medicine specialist who also is credentialed in addiction medicine. My "peers" have been orthopedic physicians, chiropractors, neurologists, anesthesiologists, internists, family physicians, and others. Most of the time they are from out of state. Their practice experience has very little to do with mine. They can hardly be considered "peers." I have to explain to them the most simple of pain management principles. They have very little idea what the special needs of my patients are. It is also abundantly obvious that they don't care, either.

Routine Denial of Care

They are conflicted. Every peer review interview that I am subject to results in denial of care or some bait and switch tactic. At first I took the high ground and gave them credit for meaning well and trying to control costs. However, since mid-2005 things have deteriorated at an alarming rate.

These doctors are part of an organized review machine and are paid to review. It should be no surprise that for the most part the reviews end in denial of requested care.

The standard reason for denial is that the recommended treatment is not supported by ACOEM Guidelines. The American College of Occupational and Environmental Medicine, with CMA support, became presumptively correct by legislative mandate as part of the Governor's comprehensive Workers' Comp reform. I sat on the CMA's Workers' Compensation TAC and in good faith supported my colleagues with assurances that the reform was necessary and that other guidelines would be incorporated as part of the "reform." This, of course, never happened. Other guidelines were considered too permissive. This translates into "too costly." And we all want to control costs, don't we?

Current Guidelines

The current ACOEM guidelines are based on the second edition textbook published by the Occupational Medicine Physicians. Somehow, this book, some 500 pages in length, has become the Bible, Torah, and Quran of medicine. It is really a boy scout's guide to medicine. Although it has a nice introduction to work-related injuries, it is wholly insufficient and lacking when it comes to pain, my area of expertise.

Because it is the controlling authority, it has been misused as a utilization review tool. I can assure you that my practice, for the most part, is not supported by the book and, therefore, it can be argued, is illegitimate.

Hundreds of patients have failed traditional medical approaches and have benefited from the care I have given them. Remember that by the time they get to me, they are in chronic pain. If I can reduce their pain by 50 percent, then I am successful. Obviously, the ACOEM - which preaches not medications but "functional restoration" and a return to work - cannot possibly apply to my patient population. My patients have chronic disease and will not get much better at all.

So? You say, too bad for them. Show them the door, and let them learn to live with their pain without medical care. I will tell you that when your turn comes up for pain management, you suddenly lose your hostility and abhorrence for pain relieving therapies, including opiate medications.

That brings me to the board-certified pain specialists in California who deny the care I have recommended. If they in fact do practice pain medicine in a practice similar to mine, then they should know better. Shame on them. There is a special ring in Dante's Inferno for them. Their "peer review" will be forthcoming from someone more powerful than I and my suffering patients.

They cite "evidenced-based medicine." They know that there is very little in print, and certainly very little indeed that supports what they do for a living. You see, clinical experience and clinical judgment is now old hat. In today's modern medical lexicon, there is only RCT, randomized controlled trials, as legitimate evidence. The ACOEM guys are pushing to have only RCTs as the basis for determining medical care.

Please. I challenge all of you, every one of you out there, to show me the RCT evidence, high quality, that supports all of what you do in your practice. Honestly. Don't tell me that the motive here is really "GOOD MEDICINE." The motive here is cost control. After all, we can't do all things for all patients, I hear.

There is much more to discuss, which I will be glad to share on subsequent correspondence. But for now, I want everyone to know that I went to doctor school to practice medicine.

If you want to practice cost control, go to business school and run a medical peer review group, or an insurance plan. I understand there is good money there.

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