



Voices of Medicine



By Del Meyer, MD

A complication of volleyball, when religion meets medicine, the draw of surgery centers.

Broken Nose, Big Problem

David Goldschmid, MD, the President of the San Mateo County Medical Society, writes about "When Doing The Right Thing Seems Wrong" in the society's April *Bulletin*.

"It is not always easy to do the right thing. Sometimes we know what the right thing is, but either choose not to do it or find ourselves in a position where we cannot. Sometimes we just do not know what the right thing is.

"My daughter recently broke her nose playing soccer. She belongs to a Boston-based HMO associated with Harvard Medical School. She called her primary physician hoping to get a referral to a surgeon who is able to fix her nose. Instead, she was offered an appointment to see her primary care physician - in two weeks.

"The medical director of the clinic explained that it was his policy to require that all referrals go through the primary care physicians, but there was a shortage of them, resulting in excessive delays. My daughter was advised that she should go to the ER if she thought she should be seen within two weeks.

"Off she went to the ER, where the resident physician ordered a CT scan of her face. Apparently, having a nasal deformity is not sufficient for a diagnosis of a nasal fracture. She was told she needed an image to confirm the diagnosis in order to facilitate a referral to a surgeon. It was their custom to always get a CT (not just nasal bones), to make sure that "nothing was missed." Worried about unnecessary radiation, she insisted that she only get plain nasal bone films if an image was required for a referral. This image showed a nasal fracture.

"The primary care physician was contacted to get a referral, but he thought that repairing a nasal fracture might be denied, as it was probably 'cosmetic.' Eventually, she got her nose fixed, but her impression of physicians was less than stellar. Suffice it to say that this real scenario is peppered with people doing the wrong thing and is a good example of the chaos that results when we forget our true purpose and limit our goals to immediate ones.

"The legitimate goal is to fix the broken nose. Her physicians forgot why they are there. The goal of the medical director is to limit cost, but his policies actually resulted in increased cost. The goal of the emergency resident is to protect himself from his colleagues' criticisms and to be sure he does not miss anything. This results in unnecessary testing and exposure to radiation. Ultimately, this is a grand failure earning physicians loss of stature..."

The entire article is at www.smcma.org/Bulletin/BulletinIssues/April07issue/When%20Doing%20The%20Right%20Thing.pdf.

The Minister's Son

The May 2007 issue of San Francisco Medicine focused on medicine and religion. The President's Message of Stephen Follansbee, MD, was entitled, "A Prescription for Prayer?"

"As the son of a Presbyterian minister, I am aware of how much I am my late father's son, despite my different career path. My voice sounds like his. My hand gestures and mannerisms are like his. I think that at times, when talking with patients about life-threatening illness, death, and dying, or advising them about how to talk with their families and friends, I must naturally rely on some of my father's innate counseling skills. Is the practice of medicine that far from religion? As physicians, are we that different from clergy? The answer is a resounding 'yes,' even though a majority of hospitalized patients would like us to consider their spiritual needs..."

"As physicians, we are certainly aware of the conflict that can arise between religion and medicine. A 2005 study entitled 'When Patients Choose Faith over Medicine: Physician Perspectives on Religiously Related Conflict in the Medical Encounter,' by Curlin, Roach, Gorawara-Bhat, Lantos, and Chin, looked at this issue. The authors conducted one-to-one, in-depth, semistructured interviews with twenty-one physicians from a broad range of religious affiliations, specialties, and practice settings. Although admittedly based on a small study sample, their conclusions are interesting. The authors categorize the conflicts between medicine and religion into three overlapping domains: religious doctrine versus medicine, ethical controversy, and faith versus medicine. The refusal of Jehovah's Witnesses to accept blood products is an example of religious doctrine. Lawsuits have been won by patients who have sued their physicians for battery after saving their lives with transfusions of red blood cells, against their expressed wishes. The courts are clear: A patient's religious convictions must be respected, even if doing so conflicts with the doctor's own judgment about appropriate medical care..."

The entire article can be found at www.sfms.org/AM/Template.cfm?Section=Article_Archives&CONTENTID=2313&SECTION=Article_Archives&TEMPLATE=/CM/ContentDisplay.cfm.

Hospitals and Surgery Centers

Phillip Goldberg, legal counsel for the California Society of Anesthesiologists, discusses "Hospitals vs. Surgery Centers" in the *CSA Bulletin*.

"The proliferation of free-standing ambulatory surgery centers in recent years has sometimes created tension between these new facilities and acute care hospitals. Most of these surgery centers are physician owned, in whole or in part, and physician investors are encouraged to steer patients to their surgery center for qualified procedures that might otherwise have been performed in the acute care hospital where the physician is on staff.

"This is not just a matter of the surgeon's financial self interest. Federal regulations actually encourage procedures at the surgery centers by providing fraud and abuse protection to a physician who performs enough procedures at the surgery center so it is considered an extension of the physician's practice. (42 C.F.R. 1001.952(r).) Many surgery centers require their surgeon investors to perform enough cases to comply with the regulatory safe harbor as a condition of retaining their investment. Generally, to fit within the fraud and abuse safe harbor, the surgeon must perform at least one-third of his or her outpatient procedures at the surgery center. Although compliance with the safe harbor is not required to comply with the federal fraud and abuse statute, many surgery centers adopt the safe harbor as mandatory for their investors, with the result of increasing utilization at the facility.

"By necessity, surgeons bring their healthier patients to the surgery center and leave their sicker patients at the hospital. By choice, the better reimbursing cases are often performed

in the surgery center, and the lower paying cases are left at the hospital. As patients are leaving the hospital and moving to the surgery center, anesthesiologists are following them. It is not uncommon for some anesthesiologists to practice principally or exclusively at a surgery center. This exodus of patients and anesthesiologists has created problems for other anesthesiologists who continue to practice principally or exclusively at acute care hospitals..."

To read more, go to www.csahq.org/pdf/bulletin/issue_16/LPAD071.pdf.

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